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POMS

PROGRAM OPERATIONS MANUAL SYSTEM

Part 04

Disability Insurance

P 89 339

5/6/89
US Docs

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CHAPTER 275

Reopenings and Administrative Finality

This consolidation includes thru TN 4.

U.S. Department of
Health and Human Services
Social Security Administration
Office of Policy
SSA Pub. No. 68-0427500
I.C.N. 991565
MAY 1989

A89018887A

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Chapter 275 - Reopenings, Adoptions and Refilings**Subchapter 01 - General****Old POMS Disability(DI) Reference****New POMS (DI) Reference**

27501.001	27501.001
27501.005	27501.005 B.1.
27501.010	27501.005 B.3.
27501.015	Deleted
27501.020	Deleted
27501.025	27501.005 C.1.
27501.030	27501.005 B.5.
27501.035	27501.005 C.4.

27500.000 Reopenings, Adoptions and Refilings

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General

NOTE:

The audience for all sections and subchapters within this chapter is the same:

PSC—CA, CRTA, CS, DE, DEC, DTE, IES, RECONR

ODIO-ODO IND-BATA, CATA, DEC, DS, ISTA, RECONC, RCOVTA

ODIO-ODO SHARE...DE, ER, IS, PLS

ODIO-OIO...CATA, ERE, FCR, FDE, RECONC

DDS...ADJ, DHU

Citations

20 CFR 404.902 - 404.905, 416.1402 - 416.1405

20 CFR 404.987 - 404.996, 416.1487 - 416.1494

27501.001 Reopenings and Revisions: Pertinent Definitions and Related Policy

A. Definitions

1. REOPENING

A formal review of a determination or decision which has become administratively final to admit new and material evidence (per DI 27505.010), or, where error is involved, a reevaluation of the evidence used in a prior determination or decision.

NOTE: The term "determination" refers to adjudications at the initial and reconsideration levels, and "decision" to adjudications at the Administrative Law Judge (ALJ), Appeals Council (AC), and Court levels.

2. REVISION

Any change in the end result or basis of a final determination or decision.

3. FINAL DETERMINATION OR DECISION

a. When final notice of the determination or decision is released to the claimant (or representative payee) at the last known address, unless the determination or decision has been timely appealed or reopened and revised under the rules for reopening.

b. Where appealed, a determination or decision becomes final on the date of notification from the highest level of appeal that has been utilized.

c. Where revised, a determination or decision becomes final as of the date of the notice of the revised determination or decision unless timely appealed or reopened and revised.

NOTE: The SSA-L1157-U2 is an interim notice and not a final notice.

B. Related Policy

1. TIMELY APPEALED

See DI 27010.001 for explanation of time limits for appeals.

2. RULES FOR REOPENING

See DI 27505.000 ff. for time limits and conditions under which reopenings and revisions may occur.

3. MEDICAL IMPROVEMENT REVIEW STANDARD (MIRS)

See DI 28005.001D.1 for when MIRS applies.

4. ADOPTION OF THE PRIOR DETERMINATION OR DECISION

See DI 27515.000 ff. for discussion.

5. REFILINGS FOR THE SAME PERIOD (RES JUDICATA)

See DI 27516.000 ff. for discussion.

6. PERIOD ADJUDICATED

See DI 27510.000 ff. for discussion of the period covered by a determination or decision which has become final.

7. REOPENING AND REVISION OF CDR DETERMINATION

See DI 28501.000ff. for discussion.

DI 27501.005

27501.005 Reopenings and Revisions: General

A. Policy Principles

A claimant may lose rights to further review if a timely appeal of an administrative determination or decision is not made.

If a determination or decision is not timely appealed and good cause for late filing an appeal does not exist, reopening and revision is at the discretion of SSA (or DDS).

B. Operating Policy

1. HOW REOPENING ISSUES MAY ARISE

- a. A party to the determination or decision requests (including implied requests) reopening by either:

- writing SSA (or the DDS);
- writing a third party (e.g., a congressman); or
- filing a new claim.

NOTE: DDS examiners should be alert to the possible reopening of a prior determination or decision if an onset date of disability is being established more than 17 months prior to the month the current application was filed.

- b. SSA (or the DDS) questions the correctness of a prior determination or decision as a result of:

- new information or evidence; or
- consistency or other review.

2. REQUIREMENTS BEFORE REOPENING

- a. An administratively final (DI 27501.001 A.3.) initial determination of disability (may be initial or CDR determination), and
- b. Reason to consider reopening (e.g., new and material evidence), and
- c. A timely written statement by a party to the determination or decision indicating disagreement with the correctness of a final determination or decision, or
- d. A timely written statement (affirmative action in writing) by an authorized component of SSA (or DDS), questioning the correctness of a prior determination or decision.
- "Timely" means within the timeframes and conditions described in DI 27505.000 ff.
 - "Authorized" means the component has the authority to reopen the determination or decision in question. (See B.3. below.)

NOTE: An initial determination may have been finally decided at the reconsideration, hearing or Appeals Council level. However, the time limit for reopening is based on the date of notice of the initial determination regardless of the level at which it is finally decided.

3. WHO MAY REOPEN

An SSA (DDS) component at the same, or higher, adjudicative level.

- Reopenings of favorable DDS reconsideration determinations to medical or medical/vocational denials are the jurisdiction of the Disability Hearing Unit (DHU). (See DI 29001.001.)

NOTE: The DDS or ODO reconsideration examiner cannot reopen a DHU decision.

- An ALJ decision affirmed by a court may be reopened by an ALJ or the AC. An AC decision affirmed by a court may be reopened by the AC.
- SGA, income and resources, or other nonmedical issue at the initial and reconsideration levels may be reopened by the FOs, ODO or PSC-DRSs.

NOTE: The FO has the authority to reopen the DDS's disability determination when an SGA, income and resources, or other nonmedical issue arises after a

B. Operating Policy

(Cont.)

3. WHO MAY REOPEN
(Cont.)

DDS has made a medical determination on a disability claim.

NOTE: An adjudicative level below the ALJ may not reopen a decision by an ALJ or the AC.

4. EFFECT OF MIRS (SECTION 2 OF PUBLIC LAW 98-480)

a. When the MIRS applies (DI 28005.001 D) a favorable disability determination or decision can be reopened and revised to a determination or decision of denial, cessation, or closed period only where:

- There is medical improvement related to the ability to work (or a Group I exception is met (DI 28020.001 ff.)) and the beneficiary/recipient can currently perform SGA. (See DI 28010.000 ff. for discussion of MIRS.), or
- A Group II MIRS exception is met (DI 28020.900).

NOTE: Disabled widow(er)s, surviving divorced spouses or children receiving benefits under title XVI require consideration of the requirements of the Listing of Impairments, rather than ability to perform SGA.

b. The MIRS does not apply to reopening and revision to a later onset or to revised determinations concerning insured status or other nonmedical issues.

5. WHEN REVISED DETERMINATION OR DECISION IS REQUIRED

- a. To make a less favorable (adverse) revision.
- b. To make a more favorable revision.
- c. To make a basis code change only—no change in the determination or decision to deny or allow, or onset or cessation date.
- d. To make a revision to a statutorily blind diagnosis, or from statutorily blind diagnosis to other diagnosis. (See DI 28080.065 for change of status from blind to disabled.)
- e. To conform conflicting determinations or decisions in common issue claims. (See DI 27515.000 ff.—adoption of prior determination or decision and DI 27520.030 for responsibilities.)
- f. To reopen certain erroneous notice/payment cases (see DI 27520.025).

6. EFFECT OF FAILURE TO MAKE A DETERMINATION

The withdrawal of an application or the failure to make a determination as to a claim is not a determination to which the rules for reopening can apply. See GN 03101.070 for discussion of what is an initial determination.

7. SCOPE OF DETERMINATION OR DECISION

- a. Unless otherwise instructed:
 - Consideration for reopening is based on the statute, regulations, and rulings which were applicable at the time of the adjudication of the determination or decision being considered.
 - A revised determination or decision is based on current statute, regulations, and rulings.
- b. A revised determination or decision must extend through the current date (or through the date last insured, age 22, or prescribed period, if earlier) rather than through the date covered by the determination or decision being revised.

8. REMINDERS

- a. Adverse reopenings other than those indicated in DI 27501.005 B.4.b. must follow the MIRS. (See DI 28010.001 ff.)
- b. Where a notice of a determination or decision has been released and new information or evidence is received indicating that improvement in the claimant's condition occurred before the end of the required 12 months duration of disability (DI 25505.001 ff.), the case is generally considered as a continuing disability issue. However, reopening of a final determination is warranted in title II claims when a claimant returns to work at the SGA level in the waiting period, per DI 24010.001 D.4.

DI 27501.005C.

B. Operating Policy**(Cont.)****8. REMINDERS (Cont.)**

- c. If evidence of improvement is received before the notice of the award is released, a new determination should be prepared, if warranted. (This action will not be considered a reopening.)
- d. Onset of disability in a subsequent title II claim may be established within a previously adjudicated period when the evaluation criteria have changed (DI 27505.020 B.ff. and DI 27510.005 B.2), or reopening is barred due to the time constraints (DI 27505.000 ff.). (Establishing an onset within the previously adjudicated period usually increases the monthly benefit amount.)
- e. See DI 27520.000 ff. for special issues.

C. Operating Procedures**1. CLAIMANT'S RIGHTS**

- a. Give the claimant the benefit of all favorable inferences that might reasonably be drawn from the evidence when considering reopening and revising.
- b. Provide the claimant a meaningful due process notice in adverse actions. (See DI 27525.000 ff.)

NOTE: A due process decision notice is provided when benefit continuation rights are applicable.

- c. Afford the claimant an opportunity to present any **additional information or evidence** he or she believes may have a bearing on the determination or decision in adverse actions. (See DI 27525.000 ff.)

2. REOPENING AND REVISION

- a. Document the file to assure all opportunities and efforts to comply with **due process** requirements have been satisfied. (See DI 27525.000 ff.)
- b. Prepare determination. (See DI 27530.000 ff.)
- c. Prepare rationale. (See DI 27535.000 ff. and DI 27536.000 ff.)
- d. Prepare proper notices and provide appeal rights. (See DI 27540.000 ff. and DI 31505.000 ff.)
- e. Route case. (See DI 32005.095.)

3. APPEAL LEVEL AFTER ADVERSE REVISION

- a. Give **reconsideration appeal rights** when the revised determination was finally decided at the initial level. Include the right to a disability hearing at the reconsideration level for adverse revisions based on medical or medical/vocational factors as indicated in DI 29001.001. **Do not give disability hearing rights at the reconsideration level if a revised determination establishes a later onset because of work.**
- b. Give **ALJ hearing rights** when the revised determination was finally decided at the reconsideration level.

NOTE: The reconsideration determination level includes disability hearing for individuals who have been receiving benefits and who have appealed an initial or revised determination that, based on medical factors, he or she is not disabled.

4. REOPENING REQUEST DENIED

- a. Document the file with Form SSA-5002, or other appropriate form, describing facts and consideration given to the reopening issue, and reason for not reopening.
- b. Provide notification of disposition of any reopening issue the claimant is aware of, but do not include right to appeal. (See DI 27540.000 ff.)

BASIC
SSA Pub. No. 68-0427500
January 1986

Audience: DO/BO/TSC: OS, RR;
PSC: CA, CRTA, DE, DEC, DTE, IES,
RECONR; ODO: BATA, CATA, DE, DEC, DS,
ER, IS, ISTA, PLS, RCOVTA, RECONC;
INTPSC: CIES, ERE, FCR, FDE, RECONC;
DDS: ADJ, DHU

Originating Office: SJH-92

PROGRAM OPERATIONS MANUAL SYSTEM
Part 04 - Disability Insurance
Chapter 275 - Reopenings and Administrative Finality
Subchapter 05 - Rules of Administrative Finality

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Background

Part 04 (Disability Insurance) of the Program Operations Manual System (POMS) has been reorganized into three user-component segments following a work or case flow sequence. These segments are: district office (DO) procedures; disability determination services (DDS) procedures; and processing center (PC) procedures.

This transmittal contains material for the DDS procedures segment. The material does not change existing policy and procedures (unless specifically noted in the "Explanation of Manual Changes.") However it may clarify or simplify certain existing instructions. In addition, references to the Social Security Act and the Code of Federal Regulations have been added where appropriate.

Explanation of Manual Changes

This subchapter provides a brief discussion of the provisions of Administrative Finality. Included are when decisions are considered to be final, claimant's rights, and several special situations. This subchapter also explains the time limit rules for reopening prior determinations. It also explains reopening for good cause on the basis of new and material evidence or error in the face of evidence. Diligent pursuit after expiration of time limit for reopening is also explained.

NOTE: Some sections of this subchapter duplicate verbatim material in POMS Part 02 (General (GN)). Refer to this subchapter's conversion chart for a list of the specific sections involved and the transmittal number of the source material. The only authoritative reference is to the source material. The Office of Retirement and Survivors Insurance is responsible for this material and has approved duplication of their material in this subchapter.

CONVERSION CHART

TN 5 7-89

Chapter 275 - Reopenings, Adoptions and Refillings

Subchapter 05- Rules for Reopening

Old POMS Disability (DI) Reference

New POMS (DI) Reference

27505.001	27505.001 A.
27505.005	27501.005 C.1.
27505.010 A.....	27501.005 B.8.
27505.010 B.....	27501.005 B.3
27505.015	27505.001 B.
27505.020	27505.001 B.2.
27505.030	27505.001 B.3. & 4.
27505.035	27505.010 A.
27505.040	27505.010 B.1.
27505.045	27505.010 B.2.
27505.050	27505.001 B.5.
27505.055	27505.005

27505.000 Rules for Reopening

	Section
Time Limits and Other Conditions for Reopening a Final Determination or Decision.....	27505.001
Late Completion of Timely Investigation: Diligent Pursuit	27505.005
Good Cause for Reopening	27505.010
Fraud or Similar Fault.....	27505.015
Change of Ruling or Legal Precedent (Change of Position).....	27505.020

Rules for Reopening

27505.001 Time Limits and Other Conditions for Reopening a Final Determination or Decision

A. Introduction

Reasons for time limits and other conditions for reopening:

- to enable entitled claimants to be able to rely on a fully favorable final determination or decision; and
- to enable SSA to accommodate valid reason to change a final determination or decision.

B. Policy Principles

1. TIME LIMITS BEGIN

The date of notice of the initial determination establishes when the time limit begins. **NOTE:** The words "notice of the initial determination" refer to the first step in a four-step administrative review system (initial determination, reconsideration, ALJ hearing, and appeals council review). The reopening period begins with the notice of the first determination in this review procedure even though the decision may be subsequently revised (see GN 04001.040 B.).

2. 1-YEAR RULE (TITLES II AND XVI)

A final determination may be reopened within one year from the date of notice of the initial determination "for any reason." However, certain adverse reopenings and revisions cannot occur unless the medical improvement regulations permit a finding that disability has ceased, or does not exist. (See DI 28005.001D.)

NOTE: "For any reason" is not to imply that revision can occur without "good reason." Total evidence must clearly show that a determination or decision is incorrect.

3. 2-YEAR RULE (TITLE XVI)

A title XVI determination may be reopened within 2 years from the date of notice of the initial determination for "good cause". (See DI 27505.010. and GN 04070.080.)

4. 4-YEAR RULE (TITLE II)

A title II determination may be reopened within 4 years from the date of notice of the initial determination for "good cause". (See DI 27505.010.)

NOTE: When a favorable determination with error on the face of the evidence is precluded from reopening because the period has expired, the case should be immediately processed in accordance with the continuing disability procedures.

5. "AT ANY TIME" RULE

A determination may be reopened at any time as follows:

- a. Title II wholly or partially favorable determination—for fraud or similar fault. (See DI 27505.015.)
- b. Title II wholly or partially unfavorable determination—to correct error on the face of the evidence or clerical error provided the net result is more favorable to the claimant. (See DI 27505.010 B.2. and 3.)
- c. Title II wholly or partially unfavorable determination—to consider any excluded impairments because the claimant's felony conviction has been overturned. (See DI 27520.020.)
- d. Title II wholly or partially favorable determination—to exclude a felony related impairment from consideration because the claimant has been convicted of a felony. (See DI 27520.020.)
- e. Title XVI—only for fraud or similar fault. (See DI 27505.015.)

C. Operating Policy

1. CHARGING THE TIME LIMITATION FOR REOPENING

Time limits are computed from the date of notice of the initial determination to the date of the written request/ statement pursuing the reopening.

2. EXPIRATION OF TIME LIMIT

Expiration of time limits is at the end of the designated period as described in B. above.

DI 27505.001C.3.

C. Operating Policy**(Cont.)****2. EXPIRATION OF TIME LIMIT (Cont.)**

- a. Where the time limit for reopening expires on a Saturday, Sunday or Federal non-workday, the period is extended to the next full workday.
- b. If favorable to the title II claimant, the period may be extended for that portion of time in which the claimant is a member of the United States Armed Forces or on active duty for training. (See GN 03101.030.)

3. TIMELY COMPLETION OF REVISION

The reopening and revision should be completed before the time limits established in DI 27505.000 ff. have elapsed. (See DI 27505.005 for late completion of timely investigation.)

D. Operating Procedures—Calculating Time**1. COPY OF NOTICE IN FILE**

Use the date shown in the initial notice.

- a. Title II denials—A copy of the computer generated or manually prepared notice should be on the right side of the file.
- b. Title XVI (allowance or denial)—The copy of the notice will be in the folder only if it was manually prepared.

2. COPY OF INITIAL NOTICE NOT IN FILE

Obtain the date of the initial notice as follows in the order shown:

- a. Title II allowances:
 - Award form SSA-101-U3 series—add 5 days to the last date written in the lower right margin after the signature.
 - Award Form SSA-3925-ED series, or SSA-2417-ED—add 5 days to the date in the computer run block.
- b. Title II denials or allowances:

Secure a master beneficiary record and use the disability adjudication date. (See SM 00510.275 ff.)
- c. Title XVI allowances or denials:
 - Secure an SSI3 query (general request) which includes the NP field data segment or an SSI2 (selective request) with NOTC field data segment. The above-mentioned field segments will show the date of the last notice and the applicable form number.
 - Secure a SSIRD (SSI Record Display) per SM 01601.400 A. and check line 14 for the necessary information.

27505.005 Late Completion of Timely Investigation: Diligent Pursuit**A. Policy Principle**

Diligent pursuit allows for revising a determination when an investigation (i.e., a written statement, per DI 27501.005 B.2.c. pursuing the reopening is made) begins within the applicable time limit, but the time limit subsequently lapses before the revision is completed.

Diligently pursued means that in light of the facts and circumstances of a particular case, the necessary action was undertaken and carried out as promptly as the circumstances permitted.

B. Operating Policy

Diligent pursuit will be presumed to have been met if the investigation and revised determination, if necessary, are completed within 6 months from the date the investigation was begun. If the investigation and revision take longer than 6 months, SSA will have to show that the issue was diligently pursued.

If the investigation was not diligently pursued to its conclusion, the determination will be revised only if the revision will be favorable to the claimant.

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B. Operating Policy (Cont.)

NOTE: Diligent pursuit does **not** apply to a reopening where there is no time limit attached to the reason for reopening.

27505.010 Good Cause for Reopening

A. Policy Principles

"Good Cause" exists when:

- new and material evidence is furnished;
- the evidence that was considered in making the determination clearly shows on its face that an error was made, or
- a clerical error in the computation or recomputation was made.

"Good Cause" does **not** exist because of a change of administrative ruling or legal precedent. (See DI 27505.020.)

NOTE: DI 28020.375 discusses further the requirements for adverse reopening of a disability determination under the "error" exception to MIRS.

B. Operating Policy

1. NEW AND MATERIAL EVIDENCE

New and material evidence is any **medical or nonmedical evidence** which was not a part of the claims file when an initial determination was made but which relates back to the period adjudicated and **shows facts that would have resulted in a different conclusion.**

Additional evidence which, by itself, would not be sufficient to reopen a final decision may cast doubt on the correctness of the determination or decision and may reflect the need for further development.

NOTE: If a DDS discovers new and material evidence that may have a bearing on the correctness of a prior ALJ, AC or court decision and reopening for good cause is still possible, the DDS should direct ODO's (or the PSC's) attention to the new evidence. (See DI 27510.005 B.1.c.) If the prior decision was made by a DHO, refer the evidence to the DHU. Also, if a DDS reconsideration determination should be reopened and revised to an adverse medical or medical/vocational determination, refer to the DHU (see DI 29001.001).

2. ERROR ON THE FACE OF THE EVIDENCE

Error on the face of the evidence exists where, on the basis of all the evidence on which the determination was based and any evidence of record anywhere in SSA or the DDS at the time the final determination was made, it is clear that the determination was erroneous.

Example: Error on the face of the evidence could exist where a medical report in file materially affecting the end result of the prior determination was completely overlooked; or there was an obvious and material misinterpretation of laboratory tests, x-rays or other medical reports; or a report which was considered in deciding the claimant's case belonged to another person.

NOTE: A shift in weight of the evidence or a difference in inference drawn from the evidence is not error on the face of the evidence.

3. CLERICAL ERROR

This refers to any clerical error which resulted in an incorrect payment. (This includes clerical errors in a determination or decision which led to an incorrect payment.) (See GN 04010.001 for further discussion.)

NOTE: A wholly or partially unfavorable determination or decision may be reopened at any time to correct a clerical error if the net result is more favorable to the claimant. (See DI 27505.001 B.5.b.)

27505.015 Fraud or Similar Fault

A. Operating Policy

1. FRAUD

Fraud exists when a claimant (or any other person acting on the claimant's behalf) with intent to defraud either:

DI 27505.015A.2.

A. Operating Policy

(Cont.)

1. FRAUD (Cont.)

- a. Makes or causes to be made a false statement or a misrepresentation of a material fact; or
- b. Conceals or fails to disclose a material fact for use in determining rights to Social Security benefits.

2. SIMILAR FAULT

Similar fault does not require fraudulent intent. It exists when a claimant or any other person either:

- a. Knowingly makes an incorrect or incomplete statement that is material to the determination; or
- b. Knowingly conceals information that is material to the determination.

B. Operating Procedures

1. WHERE DDS UNCOVERS

When the DDS believes a prior favorable determination should be considered for reopening under this rule:

- a. Contact the Field Assessment Office, Field Integrity Staff in accordance with DI 23025.020.
- b. If reopening is warranted (and the DDS has authority to reopen per DI 27501.005 B.3.), complete action, including reopening, and send the case to ODO (or PSC) for pre-effectuation review.
- c. If reopening is warranted and the prior decision was made by a DHO or OD, send the case to the DHU or OD, as appropriate.
- d. If reopening is warranted and the prior decision was made by an ALJ or the AC; send the case to ODO (or PSC), as appropriate.

2. WHERE CASE IS REFERRED TO DDS

The referring office will provide specific instructions for handling.

27505.020 Change of Ruling or Legal Precedent (Change of Position)

A. Policy Principle

A change of position exists when a policy or legal precedent previously adhered to in the adjudication of cases is changed as a result of amendments to the Social Security Act, the regulations, or the publication of Social Security Rulings.

B. Operating Policy

1. REOPENING

Where there is a change of position, a determination may be reopened and revised under the 1-year rule if the result will be favorable to the claimant.

As a general rule, benefits payable because of a change in position will be paid no earlier than the date of the change of position. Specific instructions regarding each change of position will address the beginning date for each change.

Reopening is applicable in the following cases:

- a. All pending initial, reconsideration, ALJ hearing, and Appeals Council review cases where the appeal request was timely filed or the time for filing has been extended, and cases remanded by the courts to apply the change of position.
- b. All cases where the determination was questioned by the claimant or SSA (or both) in writing within 1 year of the date of notice of the initial determination and the question occurred after the change of position or was not disposed of at the time the change of position occurred. (Instructions issued at the time of the change of position will advise what constitutes a question in writing by SSA in that particular change of position situation.)

2. NO REOPENING AND NEW APPLICATION

Where a new title II application is filed and reopening is not possible per section a. or b. above, the date of onset of disability may be placed within the period adjudicated,

B. Operating Policy**(Cont.)****2. NO REOPENING AND
NEW APPLICATION
(Cont.)**

if supported by all evidence. While there is no new evidence to establish disability under the old criteria, it is permissible to establish the onset in the period adjudicated using the new criteria. However, the retroactivity of benefits will be based on the new application.

BASIC
SSA Pub. No. 68-0427500
January 1986

Audience: DO/BO/TSC: OS, RR;
PSC: CA, CRTA, DE, DEC, DTE, IES,
RECONR; ODO: BATA, CATA, DE, DEC, DS,
ER, IS, ISTA, PLS, RCOVTA, REONE;
INTPSC: CIES, ERE, FCR, FDE, REONE;
DDE: ADJ, DHU

Originating Office: SJH-92

PROGRAM OPERATIONS MANUAL SYSTEM
Part 04 - Disability Insurance
Chapter 275 - Reopenings and Administrative Finality
Subchapter 10 - Period Adjudicated

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DI 27510.015 B.-DI 27510.040 B.(cont.).	5

Background

Part 04 (Disability Insurance) of the Program Operations Manual System (POMS) has been reorganized into three user-component segments following a work or case flow sequence. These segments are: district office (DO) procedures; disability determination services (DDS) procedures; and processing center (PC) procedures.

This transmittal contains material for the DDS procedures segment. The material does not change existing policy and procedures (unless specifically noted in the "Explanation of Manual Changes.") However it may clarify or simplify certain existing instructions. In addition, references to the Social Security Act and the Code of Federal Regulations have been added where appropriate.

Explanation of Manual Changes

This subchapter explains the period of adjudication in denial/cessation, allowance/continuance, and closed period determinations at all levels of the decision process (i.e., initial determination through court decision).

CONVERSION CHART

TN 5 7-89

Chapter 275 - Reopenings, Adoptions and Refilings

Subchapter 10- Period Adjudicated

Old POMS Disability (DI) Reference	New POMS (DI) Reference
27510.001	27510.001 A.
27510.005	27505.001 D.
27510.010 A.....	27505.001 B.
	27505.001 C.2.
27510.015	27510.001 B.
27510.020	27510.001 B.
27510.025	27510.005 B.1.
27510.030	27510.005 B.1.
	27510.001 B.1.
27510.035	27510.005 B.1.
27510.040	27510.001 B.

27510.000 Period Adjudicated

	Section
Period Adjudicated - General	27510.001
Subsequent Applications.....	27505.005

Period Adjudicated

27510.001 Period Adjudicated - General

A. Operating Policy The "period adjudicated" refers to that period covered by a determination or decision which has become administratively final and binding upon both the claimant and SSA unless a new determination or decision is made on appeal or reopening. (See DI 27501.000 ff.)

The adjudicator will usually limit his/her consideration on a subsequent claim to the period after the period adjudicated. (See DI 27510.005A.1.)

B. Exhibits Charts of Effective Date of Period Adjudicated—Later Initial Entitlement Application Filed 07/65 or Later

Exhibit 1

Last Day of "Period Adjudicated"—Below ALJ Hearing Level

	Denial	Allowance	Closed Period⁶
DIB or Freeze	Date DDS (or SSA) ¹ approved last determination of Denial-or DLI ² .	Date SSA approved determination of award ³ or last day of waiting period ⁴ .	Date DDS (or SSA) ¹ approved closed period determination-or DLI ² .
CDB	Date DDS (or SSA) approved last determination of denial-or day before age 22 ² .	Date SSA approved determination of award ³ .	Date DDS (or SSA) approved closed period determination.
DWB or CDB reen- titlement	Date DDS (or SSA) approved last determination of denial-or last day of PP ² .	Date SSA approved determination of award or (for DWB only) last day of waiting period ⁴ .	Date DDS or SSA approved closed period determination or last day of PP ² .
		Cessation	Continuance
CDR		Date disability ceased.	Date DDS or SSA approved determination of continuance (or date SSA proved determination of Resumption of Award SSA-3925-EP series) ⁵ .

NOTE:

1. Where SSA approval is required.
2. Where alternative dates are given the earlier one is the last day of "period adjudicated" unless otherwise indicated in these notes.
3. Look for SSA-101-U3 series, SSA-3687-U2.
4. Governing date when notice was sent before expiration of waiting period.
5. Governing date where benefits had been terminated or interrupted.
6. Since a closed period of disability extends the DLI, an updated earnings record should be obtained to reflect extended DLI.

DI 27510.005

B. Exhibits (Cont.)

Exhibit 2

Last Date of "Period Adjudicated"—ALJ or AC Decision			
	Denial	Allowance	Closed Period⁶
DIB or Freeze	Date of decision-DLI ¹ .	Date decision effectuated by preparing determination of award (SSA-101-U3).	Date of decision affirming or establishing a closed period or DLI ¹ .
CDB	Date of decision or day before age 22.	Same as above.	Date of decision.
DWB or CDB reentitlement	Date of decision or last day of PP.	Same as above.	Date of decision or last day of PP.
CDR		Cessation² Affirmation only: date disability ceased. ³ Affirmation with change of date of cessation: date disability ceased as determination by ALJ or AC ⁴ .	Continuance Date decision effectuated by preparing Determination of Award (SSA-101-U3 series) or resumption of award (SSA-3925 series).

NOTE:

- Where alternative dates are given, the earlier one is the last day of "period adjudicated."
- If the ALJ or AC has adjudicated a subsequent application in addition to the issue of CDR, the decision will be binding through the period adjudicated on the subsequent application.
- If the ALJ has dismissed a request for hearing treat any new application as if no hearing request was ever filed.
- If the AC (without issuing decision) should deny or dismiss a request for review of the ALJ's decision, the period adjudicated reverts to the ALJ decision.

Exhibit 3

Last Date of "Period Adjudicated" - Court Decision ¹		
	Court Affirmed²	Court Allowance
Initial	Date of last administrative decision (ALJ or AC).	Date of court decision
CDR	Date disability ceased as determined by ALJ or AC.	Date of court decision.

NOTE:

- When a case is remanded to SSA, the period adjudicated reverts to the last SSA decision (ALJ or AC) appealed to the court.
- The court only rules on evidence presented through the date of an ALJ decision.

27510.005 Subsequent Applications

A. Operating Policy

1. GENERAL

- Unless the previous final determination or decision can be reopened and revised or the disability criteria have been changed since the previous determination or decision, the adjudicator will limit his/her consideration on the new claim to the period after the period adjudicated in the previous claim.
- If there is no unadjudicated period (and no new fact or issues), process the current claim in accordance with DI 27516.000 ff.

2. "PERIOD ADJUDICATED" VS "PERIOD OF DISABILITY" UNDER TITLE II

Although the period adjudicated ends with the date of disability cessation, the "period of disability" ends with the close of whichever of the following is the earliest:

- the last day of the month before the month the claimant becomes 65;
- the last day of the month immediately preceding the termination month; or

A. Operating Policy (Cont.)

2. "PERIOD ADJUDICATED" VS "PERIOD OF DISABILITY" UNDER TITLE II (Cont.)

- c. if the claimant has performed substantial gainful activity during the 36-month period following the end of a trial work period, the last month for which benefits were paid.

NOTE: This distinction is important since a claimant may not receive benefits for overlapping "periods of disability" under the same provision of the Act.

B. Operating Procedures

1. PRIOR DETERMINATION OR DECISION CAN BE REOPENED

- a. If the previous determination was made below the ALJ hearing level (and not by a DHO or OD), reopen and revise the previous determination unless a nonmedical issue is involved or a favorable reconsideration determination is to be reopened based on medical or medical/vocational factors (DHU jurisdiction per DI 29001.001).
- b. If the previous determination was made by a DHO or OD, refer both the prior claim and subsequent application to the DHU or OD, as appropriate.
- c. If the previous decision was made by the ALJ, the AC, or a court, complete action on the current application. However, if disability is being established on the subsequent claim, do not set onset within the period adjudicated by the previous decision. Instead:
 - Direct ODO's (or the PSC's) attention to the reopening issue(s) when transmitting the file, by a statement under Remarks on an SSA-408.
 - Enter the following statement on the SSA-408 if the case is being sent to the FO, "After your action please forward the folder to ODO, Division of Appealed Claims, P.O. Box 1075, Baltimore, Maryland 21203."

2. PRIOR UNFAVORABLE TITLE II DETERMINATION OR DECISION CANNOT BE REOPENED

Evaluate any new claim evidence on its own merits and prepare a determination, including establishing the onset of disability within the period adjudicated, if:

- a. more than 12 months have elapsed since the date of notice of the initial determination on the previous claim (thereby precluding reopening for any reason) and the disability criteria have changed since the prior determination or decision (DI 27505.020 B.2.), or
- b. more than 4 years have elapsed since the date of the initial notice on the previous determination or decision (thereby precluding reopening for "Good Cause").

EXAMPLE: The WE's application for DIB filed in June 1982 was denied in September 1982 with the determination notice being released in the same month. He filed for DIB again in September 1985. This application was also denied, the initial denial notice being sent in December 1985. He filed for DIB a third time in February 1988. This application was allowed based on new and material evidence, with an onset date established in the period preceding the first application. Although the determination on the first application cannot be reopened, the second application may be reopened under the 4-year rule and benefit rights can flow from that application.

3. PRIOR FAVORABLE TITLE II FREEZE DETERMINATION OR DECISION CANNOT BE REOPENED BECAUSE 4-YEAR PERIOD HAS EXPIRED

When a subsequent claim is filed for DIB:

- a. Evaluate the total evidence of record and prepare a determination on the new claim on its own merits, and
- b. Consider the previous determination under the continuing disability procedures if the freeze determination was incorrect.

4. PRIOR TITLE XVI DETERMINATION CANNOT BE REOPENED

Evaluate any new and material evidence and prepare a determination on the new application on its own merits.

5. DEVELOPMENT NECESSARY FOR REOPENING

- a. When a reopening issue cannot be resolved at the time a subsequent claim is being allowed, process the current allowance and identify the claim for return

B. Operating**Procedures (Cont.)****5. DEVELOPMENT NECESSARY FOR REOPENING (Cont.)**

for later resolution of the reopening issue. Annotate the "Remarks" of the SSA-831-U5, SSA-832-U5, or SSA-833-U5 as follows: "Return folder to DDS after award payment—possible reopening to be developed."

- b. See DI 25501.040 ff. for related instructions on having allowed cases returned to the DDS for additional development.

6. PRIOR FOLDER LOST OR DESTROYED

When the issue of reopening arises and the prior file is lost or destroyed:

- a. Secure a master beneficiary record (SM 00510.275) for title II, or supplemental security record display (SM 01601.000 ff.) for title XVI and/or request assistance from the FO for information on the prior claim.
- b. Consider all available evidence and prepare a determination as to whether reopening is possible under the rules in DI 27505.001.
- c. See DI 28035.001 where MIRS is applicable.

BASIC
SSA Pub. No. 68-0427500
January 1986

Audience: DO/BO/TSC: OS, RR;
PSC: CA, CRTA, DE, DEC, DTE, IES,
RECONR; ODO: BATA, CATA, DE, DEC, DS,
ER, IS, ISTA, PLS, RCOVTA, RECONC;
INTPSC: CIES, ERE, FCR, FDE, RECONC;
DDE: ADJ, DHU

Originating Office: SJH-92

PROGRAM OPERATIONS MANUAL SYSTEM
Part 04 - Disability Insurance
Chapter 275 - Reopenings and Administrative Finality
Subchapter 15 - Collateral Estoppel and Res Judicata

New Material	No. of Pages
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Table of Contents (DI 27515.001-DI 27515.060).....	1
DI 27515.010 B.1.-DI 27515.045 D.....	12

Background

Part 04 (Disability Insurance) of the Program Operations Manual System (POMS) has been reorganized into three user-component segments following a work or case flow sequence. These segments are: district office (DO) procedures; disability determination services (DDS) procedures; and processing center (PC) procedures.

This transmittal contains material for the DDS procedures segment. The material does not change existing policy and procedures (unless specifically noted in the "Explanation of Manual Changes.") However it may clarify or simplify certain existing instructions. In addition, references to the Social Security Act and the Code of Federal Regulations have been added where appropriate.

Explanation of Manual Changes

This subchapter defines collateral estoppel, describing when it is in effect and necessary actions when using it. It also provides information about the Doctrine of Administrative Res Judicata. Included is the definition of Res Judicata and how it differs from Collateral Estoppel. Also included is a discussion of the Application of Res Judicata and an explanation of jurisdiction. (NOTE: The material in this subchapter is currently being updated in the light of the medical improvement review standard.)

NOTE: Some sections of this subchapter duplicate verbatim material in POMS Part 02 (General (GN)). Refer to this subchapter's conversion chart for a list of the specific sections involved and the transmittal number of the source material. The only authoritative reference is to the source material. The Office of Retirement and Survivors Insurance is responsible for this material and has approved duplication of their material in this subchapter.

CONVERSION CHART

BASIC 1-86

Chapter 275 - Reopenings and Administrative Finality
Subchapter 15 - Collateral Estoppel—Res Judicata

Old POMS Disability Insurance (DI) Reference	New POMS Reference
00301.390 D.....	DI 27515.030
00301.390 E.&F.....	DI 27515.035
00402.140 A.&B.	DI 27515.040
00402.150	DI 27515.045
00501.160 A.	DI 27515.001
	DI 27515.050

Old POMS Disability Insurance (DI) Reference	New POMS Reference
00501.160 B.	DI 27515.005
	DI 27515.010
00501.160 C.	DI 27515.020
	DI 27515.025
00501.165	DI 27515.030
00501.455	DI 27515.015

Old POMS General (GN) Reference	New POMS Reference
GN 04050.010 (TN 1) duplicated in	DI 27515.050
	DI 27515.055

New Material
DI 27515.060

27515.000 Collateral Estoppel and Res Judicata

	<i>Section</i>
Collateral Estoppel—General	27515.001
Applying Collateral Estoppel.....	27515.005
Adopting Prior Determinations or Decisions	27515.010
Adopting a Prior Title II or Title XVI Denial Determination or Decision That an Individual Is Not Disabled When a New Title II or Title XVI Claim is Being Adjudicated Within Six Months Thereafter.....	27515.015
Resolution of Conflict in Title II/Title XVI Claims.....	27515.020
Questioning Prior Finding of Fact.....	27515.025
Preparation of a Title II Disability Determination Following a Final Title XVI Determination/Decision (Charts)	27515.030
Prior Folder—DO Action.....	27515.035
~~DO Guide for Requesting Prior Folders.....~~	~~27515.040~~
Association of Prior SSI Disability/Blindness Claim With Current Title II Disability Claim.....	27515.045
~~Definition of Res Judicata~~	~~27515.050~~
Application of Res Judicata	27515.055
DDS Action on Subsequent Title II Claim— ~~Claimant Previously Denied~~ ~~Through Date Last Insured/Prescribed Period/Age 22.....~~	~~27515.060~~
~~Guide for Determining Applicability of Res Judicata~~	~~27515.065~~

Collateral Estoppel and Res Judicata

27515.001 Collateral Estoppel—General

The doctrine of collateral estoppel provides that findings of fact made on an issue in a prior action will be controlling in any subsequent action between the same parties on the same issue. To ensure that consistent findings are made on the same facts, and to avoid multiple proceedings to consider the same issue, the Social Security Regulations provide that the doctrine of collateral estoppel applies with respect to any findings of fact made in a previous determination or decision under one title of the Social Security Act which has become final. Any such findings will be controlling in any subsequent decision under another title of the Act, with respect to the same facts and the same party, unless there is reason to believe that the prior finding of fact may be incorrect. (Collateral estoppel differs from *res judicata*. (See DI 27515.050.)

The doctrine of collateral estoppel should be applied to determinations being prepared under one title, where a previous determination or decision by the Secretary of Health and Human Services on the same issue under another title has become final, and no new and material evidence pertinent to such finding or reason to question such finding is presented. Therefore, where a determination or decision of disability under one title has become final, any subsequent determination made under another title for the same period we should adopt the finding which was made on the issue of disability for the same period in the previous determination, provided that:

- A. the same definition of disability applies, and
- B. there is no reason to question that finding.

27515.005 Applying Collateral Estoppel

The Disability Determination Services (DDS) should apply the doctrine of collateral estoppel to any new title II disability claim being adjudicated following a Federal determination or decision under title XVI (for the same period) on the issue of disability or blindness which has become final, unless a different definition of disability applies or the DDS finds that there is reason to question the title XVI determination or decision (see DI 27515.025). Whether the claimant was previously found disabled (see DI 27515.010 B.) or not disabled (see DI 27515.010 C.), whether the previous finding was an initial, reconsideration, or revised determination, or an ALJ or AC decision, the doctrine of collateral estoppel should be applied, unless otherwise barred. Where the claimant no longer resides in the State of the DDS which made a previous title XVI determination which has become final, the DDS of the State in which the claimant resided when the District Office (DO) transmitted the subsequent title II claim to the DDS will have jurisdiction for any necessary action. This includes preparation of a title XVI determination as to the continuance of disability, or the reopening and revision of the previous title XVI determination. (See DI 20101.015 and DI 20101.005 A.)

When the DO cannot locate the folder of a prior title XVI claim which is needed by the DDS under the collateral estoppel guides, the DDS will redevelop the medical evidence using the medical history and release forms obtained by the DO with the title II claim. The DDS will then process the title II claim under the rules of collateral estoppel unless the redeveloped evidence causes the DDS to question the title XVI determination or decision (see DI 27515.020).

NOTE: The doctrine of collateral estoppel does not apply if the title XVI case is a conversion case, unless there has been a subsequent continuance adjudicated under the Federal criteria. (This can be ascertained by checking the SSA-833-U5 or by querying the system, i.e., if field RB:X is coded "4" the case has been continued under Federal criteria—see SM 16435 B.) If a conversion case has been continued under the Federal criteria, see DI 27515.010 B.1.) If a conversion case has not been continued under the Federal criteria, the DDS must make a wholly independent determination on the title II claim.

27515.010 Adopting Prior Determinations or Decisions

A. Claimant Previously Found Disabled Under Title II

When a title XVI disability or blindness claim is filed by a title II disability beneficiary, the DO will adopt the title II disability allowance for the title XVI claim unless a DDS determination is required on the issue of statutory blindness, or there is a CDR issue.

B. Claimant Previously Found Disabled Under Title XVI

The DO will not adopt a title XVI disability allowance for a title II application, however, because simple adoption of a finding of fact on the issue of disability may not be appropriate, e.g., the onset of disability for title II purposes will not always coincide with the onset established by the title XVI determination. If current DDS development is indicated, the DO will forward the title II claim immediately without the title XVI folder, if the title XVI folder must be obtained from another location. If current DDS development is not indicated, the DO will associate the title XVI folder before forwarding the title II case to the DDS.

Upon receipt of the title II claim and completion of any necessary development, the DDS should prepare a title II disability determination adopting the period of disability established by the previous Federal title XVI determination or decision, unless there is a reason to question the title XVI determination or decision (see DI 27515.020).

1. ONSET DATE

The DDS may establish an earlier onset date in the title II determination, if the evidence warrants this, as an onset date prior to the month of filing will generally not have been considered in the title XVI determination or decision.

If the title XVI determination or decision established an onset date later than the month of filing of the title XVI claim, this onset date should be adopted for the

DI 27515.010B.2.

title II determination, unless reopening of the title XVI decision is warranted, or if the DDS questions the title XVI determination or decision, but it cannot be reopened under the rules of administrative finality. If new and material evidence would permit reopening and revision of title XVI determination to establish an earlier onset date, see DI 27515.025 A. If new and material evidence could permit reopening and revision of a prior title XVI decision by an Administrative Law Judge (ALJ) or the Appeals Council (AC), see DI 27515.025 B. If new and material evidence establishes an onset date during the period adjudicated by a prior title XVI determination or decision, but the determination or decision cannot be reopened under the rules of administrative finality, establish a title II onset date per DI 27515.025 C.1.

If the title XVI is a conversion case which has been continued under Federal criteria, (see NOTE in DI 27515.005), the DDS should establish the title II onset as of the date of the Federal determination of continuance, unless the evidence warrants establishing an earlier onset date.

2. CONTINUANCE OF DISABILITY

The DDS may find that the period of disability established by the title XVI determination or decision is continuing. They may undertake a continuing disability review, where a question is raised as to the continuing disability. They may also establish a closed period of disability (DI 25501.005) if the evidence establishes that the claimant has the capacity to engage in substantial gainful activity at a date after the period adjudicated in the title XVI determination or decision (see DI 27510.000). Where the evidence establishes that the claimant has regained the capacity to engage in substantial gainful activity, a determination of cessation should also be prepared for the title XVI claim.

Where the evidence submitted with the title II claim establishes that more than 12 months after the date of onset established by the DDS in the title XVI determination (see DI 27515.010 B.1.), the claimant has the capacity to engage in substantial gainful activity, a title XVI determination of cessation would be appropriate, rather than reopening and revision of the title XVI determination or decision.

3. NO PRIOR TITLE II CLAIM

A title XVI application protects a claimant's rights to any benefits he/she might be eligible for under title II, until a final decision is made on the claimant's entitlement under title II or the claimant is sent a "blanket denial" paragraph.

In some cases, a title II claim may not have been taken with a prior title XVI claim, e.g., because it was erroneously assumed that the claimant did not meet the insured status requirement. In these cases, entitlement to title II benefits can be established on the basis of the title XVI application date, if it should subsequently be discovered (e.g., due to a subsequent title II claim) that the claimant met all the requirements for entitlement, during the period in which the title XVI determination or decision established disability. A closed period of disability should be established, in accordance with DI 27515.010 B.2. above, if evidence establishes that the claimant has the capacity for substantial gainful activity at a date after the period adjudicated in the title XVI determination or decision.

Example:

The claimant filed a title XVI application in June 1975, and disability was established from June 1975 on. No title II application was filed because it was erroneously assumed that the claimant did not meet the insured status requirement. When a title II claim was filed in November 1979, however, it was found that the insured status requirement had been met through December 31, 1975. Evidence submitted with the November 1979 title II claim established that the claimant had the capacity for substantial gainful activity (SGA) in May 1978. The medical evidence did not warrant establishing a title II onset before June 1975. The DDS established a closed period of disability under title II from June 1975 through the current decision date, based on the title XVI application date of June 1975. A title XVI determination of current cessation was prepared, based on the evidence establishing the claimant's capacity for SGA.

4. PRIOR TITLE II CLAIM DENIED

In some cases, concurrent title II and title XVI disability claims were taken previously, disability was established for the title XVI claim, and the title II claim was denied, e.g., due to an incorrect date last insured. In these cases, title II entitlement can be established on the basis of the prior title II application only if the prior determination can be reopened and revised under the rules of administrative finality (see DI 27501.001 ff.). Where missing wages, self employment income (SEI), etc., or DLI is the issue, the DO will, when appropriate, have reopened and revised the title II claim before forwarding it to the DDS for application of collateral estoppel. If the prior title II claim has been finally denied and cannot be reopened, entitlement must be established on the basis of the current title II application. In this situation, if the evidence submitted with the title II claim establishes that the claimant's disability ceased earlier than the 14th month prior to the month of the current title II filing, (thus precluding a closed period) prepare a title II determination of denial and a title XVI determination of cessation. Since retroactive cessations are precluded except in rare situations (e.g., SGA, fraud, etc.), the title II claim will generally result in a closed period with the ending date coinciding with the title XVI cessation date.

C. Claimant Previously Found Not Disabled (or Disability Ceased) Under Title XVI

When a title II disability claim is filed following the denial or cessation of a title XVI disability or blindness claim, the DO will forward the title II claim *without obtaining the title XVI folder*.

If the title II claim contains an allegation of the onset of disability before the apparent date of adjudication of the title XVI determination or decision (ADJ-DATE on the "SSA-450C—Prior Claims Notice," the DDS should obtain the title XVI folder in accordance with DI 20505.010. Unless there is a reason to question the title XVI determination or decision (see DI 27515.025), the DDS should prepare a title II determination denying disability for the period adjudicated in the title XVI determination or decision, except that a closed period of disability will be appropriate in the

title II claim if there was a period of disability in the title XVI claim, which did not end more than 14 months prior to the title II month of application. The DDS may establish an onset date after the period adjudicated in the title XVI determination or decision, if the evidence establishes that the claimant was unable to engage in substantial gainful activity after that period, and the disability insured status or prescribed period requirement continued to be met after the date of the final title XVI determination or decision.

D. Preparation of Title II Determination

When the DDS adopts a previous title XVI determination or decision that the claimant was or was not disabled for the period adjudicated in that determination or decision, the DDS should check item 27 (Rationale) of the SSA-831-U5 and prepare an SSA-4268-U4/C4. If a rationale has been prepared for the prior determination, the SSA-4268-U4/C4 should indicate "The findings of the prior title XVI determination or decision of (date) are adopted." The DDS should enter this statement in addition to any other statements required. Any findings for a period not adjudicated in the previous title XVI determination or decision should be rationalized in the regular manner.

27515.015 Adopting a Prior Title II or Title XVI Denial Determination or Decision that an Individual is not Disabled When a New Title II or Title XVI Claim is Being Adjudicated Within Six Months Thereafter

The DDS may adopt a prior title II or title XVI determination or decision of denial for a new title II or title XVI disability claim where all of the following conditions are present:

- A. The title II claim is for disability insurance benefit (DIB) not disabled widow(er)'s benefits (DWB) or child disability benefits (CDB) or the title XVI claim is for adult disability (not child disability);
- B. The disability insured status continues to be met in the new title II claim;
- C. The new claim is being adjudicated within six months after the prior denial decision;
- D. The DDS has a copy of the prior determination (SSA-831-U5), or decision (ALJ or AC);
- E. The basis for the prior denial was "substantive" (not currently disabled) rather than "technical";
- F. There is no indication or allegation of an additional impairment or worsening of a previously alleged impairment since the last determination or decision, and no new medical treatment is alleged; and
- G. The prior decision was prepared on or after 2/26/79 and the rationale contains the "Findings of Fact".

Since the rationale should be the same as for the prior denial determination, the DDS should check

item 27 (rationale) of the SSA-831-U5 and prepare an SSA-4268-U4/C4. If a rationale has been prepared for the prior determination, the only entry required on the SSA-4268-U4/C4 is:

"See SSA-831-U5 dated _____ for title II DIB (or title XVI Adult Disability) claim, SSN _____. The statement of evidence in the last prior denial determination (or ALJ or AC decision) dated _____ for title II DIB (or title XVI Adult Disability), except as modified herein, is hereby incorporated by reference, but not the inferences, findings, or conclusions thereon. There is no indication or allegation of a worsening of the previously alleged impairment and no new medical treatment or additional impairment(s) is alleged since such prior determination (or decision)."

27515.020 Resolution of Conflict in Title II/Title XVI Claims

The doctrine of collateral estoppel should also be used to resolve conflicting determinations or decisions which have been made by a DDS, ALJ, or AC under title II and title XVI on the issue of disability (DI 27520.085).

27515.025 Questioning Prior Finding of Fact

Under the doctrine of collateral estoppel, a determination or decision which has become final under one title will be controlling in any subsequent determination or decision under another title, unless there is a reason to question the correctness of the prior determination or decision. Under the rules of administrative finality, the correctness of a final determination or decision should be questioned only where new evidence or information is received which could result in a different conclusion, or where it is clear that the previous determination or decision was erroneous, on the basis of evidence which was in file or in the possession of SSA or the DDS, *at the time the determination or decision was made*. A final determination or decision may also be questioned within 1 year from the notice of the initial determination for "any reason," subject to certain administrative considerations in DI 27505.000. A final determination or decision may be questioned at any time where an incorrect conclusion resulted from fraud or similar fault. Otherwise, if the determination or decision was reasonable on the basis of the evidence in file and the law, regulations, instructions, and precedents in effect at the time it was made, the correctness of a final determination or decision should not be questioned merely because there is now a shift in the weight of the evidence, a different inference might be drawn from the evidence, a different evaluation rule would now apply, or the law or regulations have since been amended.

DDS action on a prior determination or decision which they question will depend on whether it was an initial, reconsidered, or revised determination, or an ALJ or AC decision, and whether it is subject to reopening and revision under the rules of administrative finality.

A. Prior Determination Can be Reopened

If the DDS cannot adopt a final title XVI initial, reconsidered, or revised determination because they question it under the guidelines above, and the determination can be reopened under the rules of administrative finality, the DDS should reopen the title XVI determination and prepare a revised determination in accordance with DI 27530.025. A consistent title II determination should be prepared on the title II claim. If it is necessary to reopen and reverse a favorable title XVI determination, provide due process to the claimant.

B. DDS Questions Prior ALJ or AC Decision

If the DDS cannot adopt a final title XVI decision by an ALJ or the AC because they question it under the guidelines above, *and the decision is subject to reopening under the rules of administrative finality*, the DDS should forward the title II and title XVI claims folders to the Associate Regional Commissioner (ARC), Programs, for coordination with Office of Hearings and Appeals (OHA), identifying the specific reason for questioning the final title XVI decision.

Upon receipt of the claims, the ARC, Programs, will coordinate with the OHA Regional Office, or as necessary through the Office of Disability (ODO) with the OHA Central Office, to request OHA to reopen and revise the questioned title XVI decision. Upon completion of any action by OHA, the claims will be returned to the DDS to prepare the title II determination.

OHA has the final authority, under the regulations, to determine whether further action is to be taken on an ALJ or AC decision. If OHA responds that no action can be taken to reopen a questioned decision, the decision must stand as the final decision of the Secretary, and the DDS must apply the doctrine of collateral estoppel in preparing the title II determination.

NOTE: In considering referral of a final ALJ or AC decision, the DDS should be aware of the priority of the ALJ or AC decision. DDS referrals should be limited, and must be strongly supported by the evidence in file and clearly documented and defined in their referral to the ARC, Programs.

C. Prior Determination or Decision Cannot be Reopened

When the DDS questions a final title XVI determination which cannot be reopened under the rules of administrative finality in DI 27505.015, their action will depend on whether the final determination or decision was favorable or unfavorable to the claimant.

1. PRIOR UNFAVORABLE DECISION

Where notice of an unfavorable initial determination on a title XVI claim was given more than 1 year prior to a change in the statutory or regulatory definition of disability (e.g., a change in the Listing of Impairments), the final title XVI determination may not be reopened on the basis of this change.

Where notice of an unfavorable initial determination on a title XVI claim was given more than 2 years ago, the final title XVI determination or decision may not

be reopened unless fraud exists. If the title XVI determination or decision cannot be reopened, DDS action on the title II claim will depend on whether new and material evidence has been received with the title II claim. DDS action will also be dependent on a change in the statutory or regulatory definition of disability; or if the quarters of coverage (QC) (or DWB/CDB eligibility) requirement continued to be met after the period adjudicated in the title XVI determination or decision.

- a. When new and material evidence is received with the title II claim which would warrant a favorable finding, a favorable title II determination can be prepared on the merits, without reference to the previous title XVI determination or decision. (Further title XVI adjudication would require a new title XVI application.)
- b. When there has been a change in the statutory or regulatory definition of disability since the title XVI determination or decision was made, a favorable title II determination can be prepared on the merits, without reference to the title XVI determination or decision. This non-applicability of collateral estoppel is true whether or not new and material evidence is received with the title II claim, and whether or not the QC (or DWB/CDB eligibility) requirements continued to be met after the period adjudicated in the final title XVI determination or decision. (Further title XVI adjudication would require a new title XVI application.)
- c. When no new and material evidence is received with the title II claim and there has been no change in the statutory or regulatory definition of disability, but the claimant continued to meet the QC (or DWB/CDB eligibility) requirement after the period adjudicated in the title XVI determination or decision, the DDS should prepare a title II determination for the unadjudicated period, through the date the QC (or DWB/CDB eligibility) requirement is last met, or through the date of the current determination, whichever is earlier.
- d. When no new and material evidence has been submitted with the title II claim, no change in the statutory or regulatory definition of disability since the title XVI determination or decision was made, and the claimant did not meet the QC (or DWB/CDB eligibility) requirement after the period adjudicated in the title XVI determination or decision, the DDS should send the title II and title XVI claims to ODO by SSA-408, without a title II determination. On its SSA-408 the DDS should cite this section as the reason for referral, and include a brief statement that the new application and evidence presents no new facts material to the issue of disability. The DDS should also request ODO to forward the prior title XVI to the DO with the title II folder, upon completion of their action on the title II claim.

2. PRIOR FAVORABLE DECISION

Where notice of a favorable initial determination on a title XVI claim was given more than 2 years ago, the final title XVI determination may not be reopened except for fraud or similar fault. If the evidence

submitted with the title II claim establishes that the claimant has the capacity to engage in substantial gainful activity at a date after the period adjudicated in the title XVI determination or decision, see DI 27515.010 B. above.

27515.030 Preparation of a Title II Disability Determination Following a Final Title XVI Determination/Decision (Charts)

Chart A—Claimant Previously Found Disabled Under Title XVI—Onset Date

If

1. Title XVI onset date is the title XVI month of filing; no evidence of earlier date of onset
2. Title XVI onset is the title XVI month of filing; evidence supports earlier date of onset
3. Title XVI onset date is later than the title XVI month of filing; no evidence of earlier date of onset
4. Title XVI onset date is later than the title XVI month of filing; evidence supports earlier date of onset and title XVI disability determination by DDS is subject to reopening
5. Title XVI onset date is later than the title XVI month of filing; evidence supports earlier date of onset and title XVI decision by ALJ/AC subject to reopening
6. Title XVI onset date is later than the title XVI month of filing; evidence supports earlier date of onset and title XVI determination/decision not subject to reopening.

Then

- Adopt title XVI onset date, or in conversion cases the date of Federal adjudication, for title II determination
- Establish title II onset date warranted by evidence
- Adopt title XVI onset date for title II determination
- Reopen and revise title XVI determination based on earlier onset date and the title XVI application date. Establish earlier onset date for title II determination
- Adopt title XVI onset date for title II determination. Enter in item 34 of title II determination "Forward title II and title XVI folders to OHA after award payment; possible earlier onset date (enter date) to be considered." Enter on SSA-408 to DO; "Upon completion of action, route to ODO, ATTN: Reconsideration Examiner. Please refer to OHA for consideration of earlier onset date for title II and title XVI."
- Establish title II onset per DI 27515.010 B.1.

Chart B—Claimant Previously Found Disabled Under Title XVI—Continuance of Disability

If

1. Title XVI determination or decision established disability; evidence establishes that claimant has a severe impairment which would preclude SGA
2. Title XVI determination or decision established disability; less than 12 months from title XVI onset claimant does not have an impairment which would preclude SGA and medical evidence establishes that claimant does not have an impairment which would preclude SGA after title II waiting period
3. Title XVI determination or decision established disability; less than 12 months from title XVI onset claimant does not have an impairment which would preclude SGA and evidence of work activity or medical evidence establishes that claimant does not have an impairment which would preclude SGA within title II waiting period
4. Title XVI determination or decision established disability; less than 12 months from title XVI onset evidence of work activity establishes that claimant did not have an impairment which would have precluded SGA before approval of the title XVI award and title XVI determination is subject to reopening

Then

- Establish an open period of disability under title II
- Prepare title XVI cessation determination. Prepare title II closed period determination where appropriate (cessation date less than 14 months preceding title II filing date, and title XVI application date protects for title II), or prepare a title II denial determination (cessation date more than 14 months preceding title II filing date, and title XVI application date does not protect for title II)
- Prepare title XVI cessation determination and title II denial determination
- Reopen and revise title XVI determination to denial and prepare title II denial determination

If

5. Title XVI determination or decision established disability; less than 12 months from title XVI onset evidence of work activity establishes that claimant did not have an impairment which would have precluded SGA before approval of title XVI award and title XVI determination not subject to reopening
6. Title XVI determination or decision established disability; less than 12 months from title XVI onset evidence of work activity establishes that claimant does not have an impairment which would preclude SGA after title II waiting period and cessation date is less than 14 months preceding title II filing date, and title XVI application date protects for title II
7. Title XVI determination or decision established disability; less than 12 months from title XVI onset evidence of work activity establishes that claimant does not have an impairment which would preclude SGA after title II waiting period and cessation date is more than 14 months preceding title II filing date, and title XVI application date does not protect for title II
8. Title XVI determination or decision established disability; more than 12 months from title XVI onset claimant does not have an impairment which would preclude SGA and there was no prior title II claim
9. Title XVI determination or decision established disability; more than 12 months from title XVI onset claimant does not have an impairment which would preclude SGA. Prior title II claim denied based on incorrect DLI and is subject to reopening
10. Title XVI determination or decision established disability; more than 12 months from title XVI onset claimant does not have an impairment which would preclude SGA. Prior title II claim denied based on incorrect DLI and cannot be reopened

Then

- Prepare title XVI cessation determination and title II denial determination
- Prepare title XVI cessation determination and title II closed period determination
- Prepare title XVI cessation determination and title II denial determination
- Prepare title XVI cessation determination and title II closed period determination
- Prepare title XVI cessation determination. Reopen and revise prior title II determination to a closed period
- Prepare title XVI cessation determination. Prepare title II closed period determination based on current title II application date (cessation date less than 14 months preceding title II filing date), (NOTE: onset of closed period will be subsequent to the prior title II denial date), or prepare a title II denial determination (cessation date more than 14 months preceding title II filing date)

Chart C—Claimant Previously Found Not Disabled (or Disability Ceased) Under Title XVI**If**

1. Title II claim alleges onset of disability during period denied (or prior to date of cessation) by title XVI determination; no evidence of disability
2. Title II claim alleges onset of disability during period denied (or prior to date of cessation) by title XVI determination; evidence establishes onset after period adjudicated by title XVI determination or decision

Then

- Prepare title II determination of denial except that a closed period of disability will be appropriate in the title II claim if there was a concurrent period of disability in the title XVI claim which did not end more than 14 months prior to the title II application month.
- Prepare title II determination establishing onset date subsequent to the title XVI decision as warranted by evidence. NOTE: Title XVI adjudication would require a new title XVI application.

If

3. Title II claim alleges onset of disability (or continuing disability) during period adjudicated by title XVI denial (or cessation) determination or decision; new and material evidence establishes onset of disability (or continuing disability) during period adjudicated by title XVI determination and prior title XVI determination by DDS can be reopened
4. Title II claim alleges onset of disability (or continuing disability) during period adjudicated by title XVI denial (or cessation) determination or decision; new and material evidence establishes onset (or continuing disability) during period adjudicated by title XVI ALJ/AC decision, and ALJ/AC decision can be reopened
5. Title II claim alleges onset of disability (or continuing disability) during period adjudicated by title XVI denial (or cessation) determination or decision; new and material evidence establishes onset during period adjudicated by title XVI DDS determination or ALJ/AC decision; prior determination or decision cannot be reopened
6. Title II claim alleges onset of disability (or continuing disability) during period adjudicated by title XVI denial (or cessation) determination or decision; evidence establishes onset of disability during period adjudicated by a title XVI determination or decision which cannot be reopened because definition of disability changed
7. Title II claim alleges onset of disability (or continuing disability) during period adjudicated by title XVI denial (or cessation) determination or decision; no new evidence material to period adjudicated by title XVI determination or decision; no change in definition of disability; and, QC or DWB/CDB eligibility requirement met after title XVI period adjudicated
8. Title II claim alleges onset of disability (or continuing disability) during period adjudicated by title XVI denial (or cessation) determination or decision; no new evidence material to period adjudicated by title XVI determination or decision; no change in definition of disability; and QC or DWB/CDB eligibility requirement not met after title XVI period adjudicated

Then

Reopen and revise prior title XVI determination to establish onset (or continuing disability) warranted by evidence and prepare title II allowance

Prepare title II determination establishing onset of disability following period adjudicated in title XVI ALJ/AC decision. Enter in item 34 of the title II determination "Forward title II and title XVI folders to OHA after award payment for possible reopening of title XVI denial decision of (Enter Date)." Enter on SSA-408 to DO: "Upon completion of action, route to ODO, ATTN: Reconsideration Examiner. Please refer to OHA, for consideration of reopening prior title XVI denial and revising the title XVI determination based on new and material evidence which establishes onset in the prior period."

Prepare title II determination establishing onset date warranted by evidence, making no reference to prior title XVI determination or decision on title II determination. If a new title XVI application has been filed, it should be adjudicated along with the title II claim.

Prepare title II determination establishing onset date warranted by evidence, making no reference to prior title XVI determination or decision on title II determination. If a new title XVI application has been filed, it should be adjudicated along with the title II claim.

Prepare title II determination for unadjudicated period through date QC or eligibility requirement last met, or through current date, whichever is earlier

Route the title II and title XVI claims to ODO citing DI 27515.001 ff., stating that the title II application and evidence present no new facts material to the issue of disability.

27515.035 Prior Folder—DO Action

A. Title XVI Claim Filed After Favorable Title II Decision

Usually, the DO can adopt a title II allowance determination for a title XVI claim. However, if the title II claim involves a closed period of disability or a visual impairment in which the requirements for statutory blindness are not met or there is a continuing disability issue, the title XVI claim must be referred to

the DDS for preparation of the title XVI determination. If the title II folder is still in the DO, the DO will prepare a folder and a Form SSA-831-U5 for the title XVI claim. The DO will include in the folder copies of all title II disability material, and forward the case to the DDS.

If the prior title II folder is no longer in the DO, the DO will not routinely request it. Instead, the DO will prepare a folder and SSA-831-U5 for the title XVI claim, include any new disability material and a photo-

copy of the title II SSA-831-U5 (if the DO has a copy) or report of contact (RC) information without the title II allowance determination, and forward the case to the DDS. (If the DO did not furnish a photocopy of the title II SSA-831-U5, check DDS records for the DDS copy.)

B. Title II Claim Filed After Favorable Title XVI Decision

When an individual files a title II claim after the DDS has returned a favorable title XVI determination to the DO, the title II case must be sent to the DDS for a determination since the title II onset must be established. If the title XVI claim is in pay status but is no longer in the DO, the DO will request the title XVI file from its current location. The DO will not routinely request the prior title XVI claim if it was a denial or a conversion case.

The DO will hold the current title II case file for association with the prior title XVI file if collateral estoppel (DI 27515.000 ff.) can be applied without current development. If the prior folder cannot be located, the DO will make this annotation in the current claim. The title II claim and any available information will then be sent to the DDS for redevelopment of the medical evidence.

If an issue that requires current development is present, the current title II file will not be held in the DO for association with the prior title XVI file. It will be forwarded to the DDS so that this development can

begin. As soon as the prior claim is received, it will be sent to the DDS for association with the current claim. Where the title II decision is complete before the prior title XVI folder is received, hold the title II folder for receipt of the title XVI folder per C. following. If the title XVI folder appears inordinately delayed, ask the DO to follow-up. If the title XVI folder cannot be located, the DO will notify the DDS by telephone.

C. Potential Conflicting Decisions

When a claim under either title II or title XVI is being processed after a prior decision of disability or blindness under the other title, the potential for conflicting decisions arises. Under certain circumstances, different decisions may be appropriate, e.g., a DWB denial and title XVI allowance, DIB denial on or before DLI and title XVI allowance. However, in most dual title II-title XVI cases, the determinations under both titles should agree. If they do not, the DDS should obtain the other claim, and consider the possibility of reopening and revising the determination on the earlier claim under the other title.

The DDS must also be alert to the possibility of conducting a CDR, where applicable, on the case under the other title. The action taken will depend on the time interval between the determinations under both titles and the nature of the disability evidence. See DI 27520.085 for complete discussion of resolving conflicting determinations.

27515.040 DO Guide for Requesting Prior Folders

DELETED PER TN 3

A. Subsequent Title II Claims—DO GUIDE FOR REQUESTING PRIOR TITLE II FOLDERS

<i>Current Claim</i>	<i>Prior Claim</i>		<i>Request Prior Folder</i>	<i>Remarks</i>	<i>Forward Folder(s) To</i>
	<i>Type</i>	<i>Status</i>			
DWB	CDB	In pay	Yes	If the prior claim is in a different PSC from that having jurisdiction of the SSN of the DWB claim.	PSC/DRS
			No	If the prior claim is in the same PSC that has jurisdiction of the SSN of the DWB claim.	PSC/DRS
DWB	CDB	Denied or Term.	No	Prepare RC. DDS may request the folder if needed.	DDS
DWB	DWB	In pay	No	Treat Applic. as duplicate claim.	
DWB	DWB	Denied or Term.	No	Prepare RC. DDS may request the folder if needed.	DDS
DWB	DIB	In pay	No	Prepare RC	ODO or PSC/DRS ¹
DWB	DIB	Denied or Term.	No	Prepare RC. DDS may request the folder if needed.	DDS
CDB	CDB	In pay	No	Treat applic. as duplicate claim.	
CDB	CDB	Denied or Term.	No	Prepare RC. DDS may request the folder if needed.	DDS
DIB	CDB	In pay	No	If the prior claim is in PSC which has jurisdiction of the DIB SSN.	PSC/DRS
			Yes	If the prior claim is in PSC which has jurisdiction of the DIB SSN.	PSC/DRS
			No	If the prior claim is in ODO. Prepare RC.	ODO
DIB	CDB	Denied or Term.	No	Prepare RC. DDS may request the folder if needed	DDS
DIB	DWB	In pay	Yes	If prior claim is in PC other than that which has jurisdiction of DIB.	ODO or PSC/DRS ¹
DIB	DWB	Denied or Term.	No	Prepare RC. DDS may request the folder if needed	DDS
DIB	DIB	In pay or freeze	No	Forward current material.	ODO or PSC/DRS ¹
DIB	DIB	Denied or Term.	No	Prepare RC. DDS may request the folder if needed.	DDS
SIB	RIB	Denied	No.		DDS

¹Based on age 59 guidelines

27515.045 Association of Prior SSI Disability/Blindness Claim With Current Title II Disability Claim

A. General

It is usually necessary to associate a prior SSI disability/blindness claim which is in pay status with the current title II claim. This is done to ensure that collateral estoppel is considered. If this prior SSI claim is available in the DO, the association should take place before the title II folder is sent to the DDS. However, a prior SSI claim which is known to be a conversion case which has not been federally adjudicated need not be associated because collateral estoppel does not apply to these cases because of differing disability criteria.

B. Requesting the Prior SSI Folder

If the prior disability/blindness SSI claim is no longer in the DO, and it is not a conversion case, query the SSI control system for its location. Request the prior SSI folder per SM 01201.035.

If the prior SSI folder cannot be obtained, the DO will notify the DDS by telephone in cases where the current title II folder has already been forwarded to the DDS. If the current title II folder has been held in the DO, it will now be annotated that the prior SSI folder could not be located and forwarded to the DDS. As appropriate, the DDS will be responsible for redeveloping the medical evidence using the medical history and release forms obtained by the DO with the title II claim.

C. Current Development Not Indicated

The DDS may be able to prepare the disability determination on the current title II claim without additional development, (including a DWB claim if the title XVI claim was allowed based on meeting or equalling the Listings) by adopting the previous title XVI determination under collateral estoppel. In this circumstance, hold the current title II claim in the DO until the prior title XVI case is received. Upon receipt, associate the two folders and forward them to DDS. Some examples of these situations are:

1. A concurrent title II claim was not taken when the title XVI claim was filed, because it was incorrectly assumed that title II disability insured status was not met, and information provided with the current title II claim does not raise a continuing disability issue;
2. A previous title II claim was taken and technically denied because disability insured status was not met. Information obtained with the current claim indicates a potential reopening because insured status was met at the onset date established by the prior title XVI determination and a continuing disability issue is not raised;
3. The claimant first meets disability insured status after the onset date established by the prior title XVI determination. The DO determines that the subsequent work activity which established insured status is not substantial gainful activity

and no other continuing disability issue is raised by the current title II claim.

D. Current Development Indicated

In most instances, the DDS will need to develop additional evidence of the claimant's condition subsequent to the title XVI determination, or currently. In these cases, if the prior title XVI case must be requested, do not hold the current title II claim in the DO. The current claim should be immediately sent to the DDS, so that the necessary development can be initiated without waiting for the prior claim. Enter in item 11 on the SSA-831-U5 "Prior SSI Claim Has Been Requested: Title XVI DOE (ENTER: NONE OR APPROPRIATE DATE.)" The reason for the referral should be indicated in the file (SSI query and/or Report of Contact). The DDS will telephone the DO if the information is missing. The case may then be returned to the DO if the telephone call indicates that immediate referral to the DDS was improper. When the prior folder is received and after any CDR action necessary, it will be sent to the DDS for association with the current claim. The following are examples of situations in which the current claim should not be held in the DO to await the prior title XVI folder.

1. A concurrent title II claim was not taken when the title XVI claim was filed, because it was incorrectly assumed that title II disability insured status was not met; however, information provided with the current title II claim raises a continuing disability issue in the period following the prior title XVI determination.
2. The claimant first met disability insured status after the onset date established by the prior title XVI determination, and the DO determines that the subsequent work activity raises a continuing disability issue.
3. The claimant first met disability insured status after the onset date established by the prior title XVI determination. The DO determines this work activity was not SGA, but information provided with the current title II claim raises a question of possible medical recovery.

27515.050 Definition of Res Judicata

Res judicata is a rule in civil law that, simply stated, provides that once a claim is decided it does not need to be decided again. Res judicata applies where there is a final determination previously made with respect to the rights of the same party, on the same facts, pertinent to the same issues. (See DI 27515.001 ff. for a discussion of collateral estoppel.)

27515.055 Application of Res Judicata

The application of the doctrine of administrative res judicata can best be understood in the context of the administrative appeals process.

Whenever an individual files a claim for benefits, SSA is required to send a notice of its determination regarding such claim and to provide an appeal paragraph. The appeal paragraph provides the individual the opportunity to have his/her case considered within

60-day periods by different people at different levels. It is important to note that the case will be considered whether new evidence is presented or not.

In the administrative appeals process there are three steps: reconsideration, ALJ hearing, and Appeals Council review. The individual can request judicial review after exhaustion of the administrative remedies.

If an individual fails to avail himself/herself of the appeals process (does not file a request timely) and files another application but nothing changes, the adjudicator can apply the doctrine of res judicata. Thus, res judicata would apply when: (1) the law or regulations have not changed thereby raising new issues; (2) no new evidence or facts are presented; and (3) the date the nondisability factors for entitlement were last met has not changed. Since we have the same person, the same issue, and the same facts and we have already issued a decision to that person which has become final (no appeal filed timely), then res judicata protects SSA from having to consider the same claim (on which it has already issued a decision) again and again, potentially ad infinitum. In the notice provided on the subsequent claim, SSA tells the individual that the decision reached on the first application applies to this application; i.e., that res judicata applies. The notice also advises the individual that the appeal available to him/her is only on the question of whether we have the same issue, the same facts, and the same person. If anything has changed, the adjudicator will not apply res judicata but will adjudicate the subsequent claim in the usual manner.

The above principles apply to initial determinations involving postadjudicative medical and nonmedical issues as well as issues involved with the filing of additional and subsequent applications.

27515.060 DDS Action on Subsequent Title II Claim - Claimant Previously Denied Through Date Last Insured/Prescribed Period/Age 22

A. General

The doctrine of res judicata should be applied to deny a subsequent title II disability claim when:

1. A prior claim—which has become final—was denied through the date on which the claimant last met the nondisability requirement for entitlement (i.e., date last insured for DIB; ending date of the prescribed period for DWB; or attainment of age 22 for CDB); and
2. the subsequent claim presents no new facts or issues which were not considered in making the determination or decision on the prior claim, including new and material evidence (see DI 27505.040), or the alleged onset of a significant new impairment during the previously adjudicated period.

Subsequent title II disability claims which meet the criteria shown above will be handled as follows:

The FO will forward the prior title II claims folder with the subsequent claim to the DDS for review.

Item 11 of the SSA-831-U5 will have been annotated by the FO to show: "Prior claim attached. Review for application of res judicata." (SSA has jurisdiction for any subsequent claim which presents no new facts or issues—i.e., in which a prior medical/vocational determination or decision was made on or after January 6, 1986, under the revised evaluative criteria, and denied disability through the date on which the claimant last met the nondisability requirement for entitlement. These cases will be denied technically in the FO or PC, and will not be forwarded to the DDS for review.)

The DDS will review the prior and subsequent claims to determine if the disability criteria applied to decide the prior claim have become less restrictive (see DI 27515.065 for guides in making this determination), and if the subsequent claim presents new facts which were not considered in making the determination or decision on the prior claim. (For subsequent claims which were held in accordance with teletypes IT-21-86 and IT-73-86, the FO's were instructed not to inconvenience claimants by requesting updated medical releases and/or an SSA-3368-F8 unless the prior folder cannot be located. If the DDS review finds that such materials are needed, the DDS will request FO development via an SSA-883-U3.)

The FO will have documented the title II claims folder to show any SSI involvement. Included in this documentation will be the location of the SSI folder as well as the date of any SSI eligibility based on a period of disability. If the DDS finds that the evidence in the SSI folder is needed before a determination can be made on the subsequent title II claim, the DDS will follow the instructions in DI 20505.015 for obtaining the SSI folder.

NOTE: If all FO attempts to secure the prior title II folder are unsuccessful, the prior folder will not be reconstructed. The FO will have annotated item 11 of the SSA-831-U5 to show: "Prior claim not located - substantive determination needed." In such an instance, the DDS will prepare a substantive medical/vocational determination on the subsequent claim.

B. Res Judicata Denial

1. If the disability criteria have not become less restrictive since the prior determination or ALJ, AC, or court decision, and if the subsequent claim presents no new facts, res judicata will apply. In these cases, the DDS will complete only the following items of the SSA-831-U5:
 - a. Item 19 (Claimant Not Disabled) - Check block B and insert either the date last insured, the end of the prescribed period, or the date of attainment of age 22, as appropriate.
 - b. Item 25A - Check block A.
 - c. Item 26 (List No.) - Enter "243" (subsequent claim-prior claim medically denied through date nondisability factors last met).
 - d. Items 30 and 31 (Disability Examiner- DDS/Date) - Self explanatory.

*Chapter 275 - Reopenings, Adoptions and Refilings**Subchapter 16 - Refilings for the Same Period (Res Judicata Cases)***Old POMS (DI) Reference**

27515.050
27515.055
27515.060

New POMS (DI) Reference

27516.001
27516.001 B.I.
27516.005

Old POMS (DI) Reference

27515.065

New POMS (DI) Reference

27516.010

27516.000 Refilings for the Same Period (Res Judicata Cases)

	<i>Section</i>
Refilings for the Same Period (Res Judicata Cases).....	27516.001
DDS Action on Subsequent Title II Claim—Claimant Previously Denied Through Date Last Insured/Prescribed Period/Age 22.....	27516.005
Guides for Determining Applicability of Res Judicata.....	27516.010

Refilings for the Same Period (Res Judicata Cases)

Citation Social Security Act 205(a)
 Regulation—20 C.F.R. 404.957(c)(i)

27516.001 Refilings for the Same Period (Res Judicata Cases)

A. Policy Principle A claim will be denied using the legal principle of res judicata when a **prior determination under the same title**:

- **has become final** (no timely appeal); and
- considers the **same facts and issues** for the **same period**.

B. Operating Policy

1. APPLICATION

Res judicata will be the basis for denial of a subsequent title II disability claim when:

- a. the prior claim has become final and was denied through the date the nondisability requirements for entitlement were last met (i.e., date last insured for DIB; ending date of prescribed period for DWB; age 22 for CDB);
- b. the law or regulations pertaining to the alleged disabling condition have not changed (see DI 27516.010);
- c. the subsequent claim presents no new facts or issues which were not considered in making the prior determination, including new and material evidence (see DI 27505.040); and
- d. an onset of a significant new impairment during the previously adjudicated period is not alleged.

2. NOTICE

The notice on a res judicata case will inform the claimant that:

- a. the **decision reached** on the prior application applies; and
- b. the only **appeal available** is on the question of whether the same person, facts and issues were present in both the prior and subsequent claims.

27516.005 DDS Action on Subsequent Title II Claim - Claimant Previously Denied Through Date Last Insured/Prescribed Period/Age 22

A. Operating Policy

1. JURISDICTION

- a. **SSA FOs have jurisdiction** for claims meeting all the criteria in DI 27516.001 B.1.
- b. **DDSs have jurisdiction** where a claim has been denied through the date nondisability requirements are met but any one of the other criteria in DI 27516.001 B.1. is not applicable.

NOTE. Due to revised evaluation criteria, the DDSs have jurisdiction **where a prior determination was made before January 6, 1986**, and denied through the date nondisability requirements are last met (see DI 27516.010).

2. FOLDERS TO BE SENT TO DDS

The FO will obtain and send to the DDS the **prior and subsequent title II claims** folders in 1.b. above.

NOTE: If the prior title II folder cannot be located, it will not be reconstructed. A substantive determination will be prepared on the subsequent claim.

3. FO's DOCUMENTATION FOR DDS CASES

- a. The FO will document the claims folder to show any SSI involvement, including location of SSI folder. If evidence in SSI folder is needed, follow DI 20505.015.
- b. Item 11 of the SSA-831-U5 will show either:
 - "Prior claim attached. Review for application of res judicata," or
 - "Prior claim not located—substantive determination needed."

B. Operating Procedure

1. **DDS REVIEW OF PRIOR AND SUBSEQUENT CLAIMS**
 - a. Follow the guides in DI 27516.010 and determine if the disability criteria applied to decide the prior claim have become less restrictive.
 - b. Determine if new facts which were not considered in making the prior determination are present.
2. **RES JUDICATA DENIAL**

Apply res judicata to deny the subsequent claim **if**:

 - a. the disability **criteria have not become less restrictive** since the prior determination, ALJ, AC, or court decision; and
 - b. the subsequent **claim presents no new facts**.
3. **COMPLETION OF SSA-831-U5 FOR RES JUDICATA DENIAL**

Complete **only** the following:

 - a. Item 19 (Claimant Not Disabled) - Check block B and insert either date last insured, end of prescribed period, or date attained age 22, as appropriate.
 - b. Item 25A - Check block A.
 - c. Item 26 - (List No.) - Enter "243" (subsequent claim—prior claim medically denied through date nondisability factors last met).
 - d. Items 30 and 31 (Disability Examiner - DDS/Date) - Self explanatory.
 - e. Item 34 (Remarks) - Show "The issue of disability is res judicata."
 - f. Item 35 (Basis Code) - Enter "S1" (res judicata).
4. **ROUTING OF RES JUDICATA DENIAL**

Return the case to the FO by a route slip annotated: "Res judicata applicable to claim filed on (date of subsequent application). Please input S1 denial and prepare an SSA-5015-U2 listing for listing code 243."
5. **DDS SYSTEMS INPUT AND CLEARANCE OF RES JUDICATA DENIAL**
 - a. Destroy "Data Copy" of SSA-831-U5.
 - b. Clear case as a folder movement clearance to FO.
 - c. Record "S1" determinations on State Agency Operating Report as denials.
 - d. Enter D831 clearance input with a systems override code of C. (See SM 06001.353.)

NOTE: The S1 denial entry by the FO will generate a notice to the claimant. Thus, no notice will be prepared by the DDS.
6. **RECON AFFIRMATION OF RES JUDICATA DENIAL**

Follow instructions in 3., 4., and 5. above with the following exceptions:

 - a. Check block 25 (Revised Det) and 25 A. B. (Recon).
 - b. Item 34 (Remarks) - Enter "Recon Affirmation—Res judicata applies."
7. **SUBSTANTIVE DETERMINATION REQUIRED - RES JUDICATA NOT APPLICABLE**
 - a. Prepare a substantive medical/vocational determination per usual procedures **if**:
 - the disability **criteria have become less restrictive** since the prior denial determination (DI 27516.010); or
 - the subsequent **claim presents new facts** which were not present in the prior claim; or
 - b. Enter the following in items 26 and 34 of the SSA-831-U5:
 - Item 26 (List No.) - Enter "243" (subsequent claim—prior claim medically denied through date nondisability factors last met).
 - Item 34 (Remarks) - Enter the following: "Res judicata not applicable."

NOTE: If the applicability of res judicata could not be determined because the prior folder was not located, enter "Res judicata not applied—prior claim not located" in item 34. Also, enter listing code 243 in item 26 for cases where the prior folder could not be located.

B. Operating Procedure (Cont.)**8. CRITERIA FOR REOPENING PRIOR CLAIM ARE MET**

- a. If a basis for reopening and revising the final determination on the prior claim exists (new and material evidence, error on the face, etc.), see DI 27501.001 ff.
NOTE: A final determination/decision can only be reopened and revised "for any reason," including a change in criteria, within 12 months from date of notice of the initial determination on a claim.
- b. If the prior decision was issued by an ALJ, AC, or court, and can be reopened under the rules for reopening, forward prior and subsequent claims to ODO per DI 27520.070; however,
- c. If the prior determination was made by a DHO, forward both the prior and subsequent claims to the DHU.
- d. **If change in disability criteria warrants disability being established** on the current application, i.e., claimant now meets disability criteria before nondisability requirement last met, prepare a substantive determination on the new claim before referring.
NOTE: This means going into the period previously adjudicated even though the time periods for reopening have not expired. This is permissible because the determination on the new claim is based on a change in the disability criteria, and does **not** reopen the decision on the prior claim.

9. PRIOR CLAIM CANNOT BE REOPENED

- a. Make a new initial determination if:
 - the final prior determination or ALJ, AC, or court decision cannot be reopened under the rules for reopening; and
 - a favorable determination within the prior adjudicated period is warranted because the disability criteria have changed or new and material evidence has been submitted since the prior determination/decision (DI 27520.060).
- b. Since the prior determination could not be reopened, **benefit rights flow** only from the new application, see DI 27520.060.

27516.010 Guides for Determining Applicability of Res Judicata**A. Introduction**

The information in B. through C. below:

- provides guides for determining the applicability of res judicata to subsequent title II disability claims;
- reflects changes in the disability evaluation criteria resulting from the Social Security Disability Benefits Reform Act of 1984 (P.L. 98-460); and
- shows how these changes affect the applicability of res judicata.

B. Operating Procedure**1. MULTIPLE IMPAIRMENTS**

Regardless of whether the prior determination was based on a not severe impairment:

- a. **Prepare a substantive determination** on any subsequent claim involving multiple impairments filed after a prior denial (made on or before November 30, 1984) through date last insured/prescribed period/age 22.
- b. **Process** per DI 24505.005 ff.
- c. **See DI 27516.005** for completing the SSA-831-U5.

NOTE: Res judicata would apply if the prior determination was made after November 30, 1984, and there have been no other changes in the criteria or facts in the case.

2. NOT SEVERE IMPAIRMENTS

- a. Prepare a substantive determination on any subsequent claim involving a not severe impairment(s) filed after a prior denial (made on or before December 24, 1985) through date last insured/prescribed period/age 22.
- b. **Process** per DI 24505.001-DI 24505.005.

DI 27516.010B.3.

B. Operating Procedure (Cont.)**2. NOT SEVERE IMPAIRMENTS (Cont.)**

c. See DI 27516.005 for completing the SSA-831-U5.

NOTE: See DI 32520.001 for States and territories where a not severe denial is precluded by a court order.**3. MENTAL IMPAIRMENT**

Because of extensive changes in the mental impairment criteria:

- a. Prepare a substantive determination on any subsequent title II mental impairment case filed after a prior denial (made on or before August 27, 1985) through date last insured/prescribed period/age 22.
- b. Evaluate per DI 24505.025 ff and DI 24510.075 ff.
- c. See DI 27516.005 when completing the SSA-831-U5.

4. PHYSICAL IMPAIRMENTS

Use the summary in C. below to determine if there has been a less restrictive change in the criteria for evaluating an impairment.

NOTE: Subsequent claims involving **multiple impairments** must receive a **substantive determination** (see 1. above). The instructions in a., b., and the exhibit at subsection C. below refer only to claims involving a single physical impairment.

- a. **Applicable Criteria Less Restrictive**—Prepare a substantive determination on the subsequent claim, if the listing criteria applicable to the impairment in the prior claim have become less restrictive. (See DI 27516.005 B.7.)
- b. **Applicable Criteria Not Less Restrictive**—A subsequent claim filed after a prior denial (made before January 6, 1986) through date last insured/prescribed period/age 22 may be denied based on res judicata, if the listing criteria applicable to the impairment in the prior claim have not become less restrictive.

NOTE: If subsequent claim presents new facts, prepare a substantive determination.**C. Exhibit**

**SUMMARY OF LESS RESTRICTIVE CHANGES TO LISTING OF IMPAIRMENTS
AS OF JANUARY 6, 1986**

NOTE: Where a listing for a particular impairment is not in this summary, a less restrictive change was not made and a subsequent claim involving the impairment may be denied based on res judicata, absent new facts.

Adult Listings	Change	Action
1.04 - Arthritis of one major joint in each of the upper extremities (due to any cause)	Requirement for joint enlargement or effusion in affected joints was removed from the heading and placed in section B.	Prepare substantive determination on subsequent claim involving this impairment.
1.08 - Osteomyelitis or septic arthritis (established by x-ray)	Expanded to include septic arthritis.	Prepare substantive determination on subsequent claim involving septic arthritis.
3.02 - Chronic Pulmonary Insufficiency	Revision of Table 1 makes the two values used in this table more consistent. Revision of the values makes them more accurate for taller individuals. (Less restrictive change since the requirements are less stringent for taller persons.)	Prepare substantive determination on subsequent claim involving chronic obstructive pulmonary disease.
3.02C - Chronic Impairment of gas exchange (due to any cause)	Data for the measurement of gas exchange now include values for testing during controlled exercise. Evaluators are encouraged to make greater use of additional tests in certain cases. This will result in allowance for claimants whose impairment is not correctly shown by more routine tests.	Prepare substantive determination on subsequent claim involving this condition.

C. Exhibit (Cont.)

Adult Listings	Change	Action
4.04 - Ischemic heart disease with chest pain of cardiac origin as described in 4.00E.	Addition of Listing 4.04A.2. to provide for evaluation of a junctional depression occurring during exercise (in addition to previously considered horizontal or downsloping ST segment depression). This revision further distinguishes characteristics between ischemic and non-ischemic heart disease.	Prepare substantive determination on subsequent claim in which a treadmill exercise test shows a junctional depression.
	Listing 4.04A.4. was formerly Listing 4.04A.3. and required an ST segment elevation to 3 mm. or greater. It now requires an ST segment elevation of 1 mm. or greater.	Prepare substantive determination on subsequent claim involving an ST segment elevation up to 3 mm.
	Evidence obtained by the radio-isotopic method, a method being increasingly used to determine heart abnormalities, was added to 4.04B.	Prepare substantive determination on subsequent claim involving evidence of ischemic heart disease obtained by the radio-isotopic method.
4.13 - Peripheral arterial disease	The title was changed from "arteriosclerosis obliterans or thrombo-angitis" to "peripheral arterial disease." Additional criteria were provided for the measurement of adequate blood supply in the legs.	Prepare substantive determination on subsequent claim involving peripheral arterial disease.
5.05 - Chronic liver disease (e.g., portal, postnecrotic, or biliary cirrhosis; chronic active hepatitis; (Wilson's disease)	This listing uses a finding of fluid accumulation in the abdomen in combination with evidence from a liver biopsy to evaluate liver disease. A new section allows this finding to be used in the absence of liver biopsy, and substitutes a requirement that fluid accumulation must be present for a longer period of time than is required when a liver biopsy has been obtained.	Prepare substantive determination on subsequent claim involving chronic liver disease where the previous determination was made in the absence of a liver biopsy.
7.05 - Sickle cell disease, or one of its variants	Chronic anemia was added to the listing for sickle cell disease.	Prepare substantive determination on subsequent claim involving sickle cell disease with findings indicative of chronic anemia.
7.17 - Aplastic anemias or hematologic malignancies (excluding acute leukemia)	New listing that is used whenever there has been a bone marrow transplant. It provides that a presumption of disability will apply for 12 months after a transplant. Evaluation is then made regarding the degree of improvement, prompting a denial/cessation when warranted. Under old listings, most claimants with a bone marrow transplant would not meet any listing since their blood studies usually become normal following a transplant. This new listing provides a time period requirement to determine if improvement following the transplant is sustained.	Prepare substantive determination on subsequent claim involving a bone marrow transplant.
11.09 - Multiple sclerosis	New paragraph provides criteria for evaluating the impairment of individuals who have no muscle weakness at rest, but do develop muscle weakness on activity resulting from fatigue.	Prepare substantive determination on subsequent claim involving multiple sclerosis with muscle weakness on activity as a result of fatigue.

DI 27516.010C. (Cont.)

C. Exhibit (Cont.)

Adult Listings	Change	Action
13.13 - Malignant neoplastic disease of the lungs	A revision of the listing that provides for evaluation of malignant lung tumors reflects current medical knowledge regarding the expected course of squamous cell carcinoma and other histologic (tissue) types of carcinoma.	Prepare substantive determination on subsequent claim involving squamous cell and other histologic types of carcinoma.
13.16 - Malignant neoplastic disease of the esophagus or stomach	Previously, the requirement was more stringent for tumors located in the lower half of the esophagus than for those located in the upper half. The revision removes this requirement and is less restrictive for claims involving tumors in the lower half of the esophagus.	Prepare substantive determination on subsequent claim involving a tumor located in lower half of esophagus. Absent new facts, a subsequent claim involving tumor of upper esophagus or the stomach may be denied based on res judicata.
13.19 - Malignant neoplastic disease of the liver or gallbladder	Revised criteria for evaluation of tumors of the bile ducts now require less extension of the tumors.	Prepare substantive determination on subsequent claim involving tumor of the bile ducts. Absent new facts, subsequent claims involving tumors of the liver or gallbladder may be denied based on res judicata.
13.29 and 13.30 - Malignant neoplastic disease of the penis and vulva	These new listings give standards for tumors of the penis and vulva.	Prepare substantive determination on subsequent claim involving these conditions.

NOTE: Per DI 24560.001, an individual with documented chronic myelogenous leukemia should be considered to have an impairment equal to Listing 13.27. This involves a less restrictive change, requiring a substantive determination.

BASIC
SSA Pub. No. 68-0427500
January 1986

Audience: DO/BO/TSC: OS, RR:
PSC: CA, CRTA, DE, DEC, DTE, IES,
RECONR; ODO: BATA, CATA, DE, DEC, DS,
ER, IS, ISTA, PLS, RCOVTA, REONE;
INTPSC: CIES, ERE, FCR, FDE, REONE;
DDS: ADJ, DHU

Originating Office: SJH92

PROGRAM OPERATIONS MANUAL SYSTEM
Part 04 - Disability Insurance
Chapter 275 - Reopenings and Administrative Finality
Subchapter 20 - Special Issues

New Material	No. of Pages
Conversion Chart.....	1
Table of Contents	
(DI 27520.001-DI 27520.090).....	1
DI 27520.010 A.-DI 27520.090.....	7

Background

Part 04 (Disability Insurance) of the Program Operations Manual System (POMS) has been reorganized into three user-component segments following a work or case flow sequence. These segments are: district office (DO) procedures; disability determination services (DDS) procedures; and processing center (PC) procedures.

This transmittal contains material for the DDS procedures segment. The material does not change existing policy and procedures (unless specifically noted in the "Explanation of Manual Changes.") However, it may clarify or simplify certain existing instructions. In addition, references to the Social Security Act and the Code of Federal Regulations have been added where appropriate.

Explanation of Manual Changes

This subchapter deals with special issues involved in reopenings. Included are informal remands, subsequent applications, death after denial or cessation, return to work within 12 months of onset, reopening after conviction of a felony, erroneous payment cases, and conflicting determinations

CONVERSION CHART

TN 5 7-89

Chapter 275 - Reopenings, Adoptions and Refillings

Subchapter 20- Special Issues

Old POMS Disability (DI) Reference

New POMS (DI) Reference

27520.001	27520.001 A.
27520.005	27520.001 C.
27520.010	27520.001 C.
27520.015	27520.005
27520.020	27520.005 B.3.a.
27520.025	27520.005 B.3.b.
27520.030	27520.005 B.3.c.
27520.035	27520.035
27520.040	27520.001 C.3.c.
27520.045	27520.005 A.4.
27520.050	27520.010
27520.055	27501.005 B.8.b.
27520.060	27510.005
27520.065	27520.015
27520.070	27505.010 B.1.
27520.075	27520.020
27520.080	27520.025
27520.085	27520.030
27520.090	27510.005 B.5.

27520.000 Special Issues

	Section
Informal Remand of ALJ Hearing Cases.....	27520.001
DDS Action Upon Receipt of Informal Remand Cases.....	27520.005
Death After Medical Denial or Cessation.....	27520.010
Previous Denial, Closed Period, or Termination Based on Failure to Follow Prescribed Treatment.....	27520.015
Previously Favorable or Unfavorable Title II Determination or Decision - Felony Related Impairment.....	27520.020
Erroneous Notice/Payment Cases.....	27520.025
Conflicting Determinations or Decisions in Disability/Blindness Common Issue Claims.....	27520.030
Exhibits: Model Language for Title XVI Applicants (Informal Remands).....	27530.035

Special Issues

27520.001 Informal Remand of ALJ Hearing Cases

Citations

20 C.F.R. 404.941, 416.1441

A. Policy Principles

1. GENERAL

- a. Before an ALJ hearing is held, a prehearing case review may be done by the component that issued the determination being reviewed.
- b. The component doing the prehearing review will decide whether the determination may be revised.
- c. The revised determination may be wholly or partially favorable.
- d. The prehearing case review will not delay the scheduled hearing unless the claimant agrees in writing to continue the review and delay the hearing.

2. WHEN A PREHEARING REVIEWING MAY BE CONDUCTED

- A prehearing case review may be conducted if:
- a. additional (consequential) evidence is submitted;
 - b. there is a change in the law or regulation, or
 - c. there is error in the file or some other indication that the prior determination may be revised.

3. NOTICE OF A PRE-HEARING REVISED DETERMINATION

- a. Notice will be mailed to all known parties at their last known address, explaining:
 - the basis for the revised determination, and
 - the effect of the revised determination, and
 - the rights of hearing (see "b" and "c" following).
- b. Where the revised determination is wholly favorable, the notice will also explain:
 - that the administrative law judge will dismiss the hearing request unless a party requests that the hearing proceed, and
 - that a request in writing to continue must be made within 30 days after the date the notice of the revised determination is mailed.
- c. Where the revised determination is partially favorable, the notice will explain that the hearing will continue unless all parties agree to dismiss the hearing request.

B. Operating Policy

1. GENERAL

Informal remand provides for a prehearing case review for hearing cases in which there is a strong likelihood for a reversal of a reconsideration determination.

2. RELATED POLICY

Refer to DI 29005.040 B. if the reconsideration determination was issued by a disability hearing officer (DHO) or by the Office of Disability (OD).

C. Background

1. IDENTIFICATION OF CASES AND ACTIONS BY FIELD OFFICES

- a. Hearing cases described below will be transmitted to the DDS with the HA-501-U5 (Request for Hearing) and the SSA-408 route slip annotated, "DDS Informal Remand Case."
 - Cases in which new evidence reveals a dramatic worsening of the claimant's condition and/or a significant new impairment of which the DDS was not aware, and
 - Cases which contain an initial SSA-832-U5 or SSA-833-U5 with a basis code of 62 or 13 in item 11. These cases represent title II/title XVI and title II-title

C. Background (Cont.)

1. IDENTIFICATION OF CASES AND ACTIONS BY FIELD OFFICES (Cont.)

XVI determinations of cessation in which the recipient had failed to cooperate in providing evidence necessary for a continuing disability decision.

- b. When a case is transmitted to the DDS per "a." above, a copy of the HA-501-U5 will be forwarded by the FO to the Office of Hearings and Appeals (OHA) office which would have received the case.
- c. Hearing cases not meeting the above criteria will be forwarded directly to the OHA hearing office.

2. IDENTIFICATION OF CASES AND ACTIONS BY THE PROCESSING CENTER AND THE OFFICE OF PROGRAM INTEGRITY REVIEW

Cases undergoing post adjudicative review when a hearing request is received will be:

- completed by the reviewing component within 3 working days,
- annotated with the applicable criteria for the reversal action where appropriate, and
- forwarded to the FO for necessary action.

3. IDENTIFICATION OF CASES AND ACTIONS BY OHA

OHA offices will forward cases to the DDS for development and review of the reconsideration prior to the hearing where:

- There is a change in law, regulations, or other precedents which could permit a finding favorable to the claimant; or
- Additional significant medical evidence is submitted with the request for hearing and the case will not be scheduled for a hearing for at least 60 days; or
- Additional existing medical evidence is requested through the DDS (DI 29501.005); or
- A consultative examination is being ordered (DI 29501.010).

OHA has the responsibility for the resultant dismissal of hearing requests where the determination is wholly favorable or proceeding with the hearing, if necessary, where the determination is only partially favorable (per C.1.a. and C.2. above). (A hearing request dismissal can be agreed to by all parties in a case with a partially favorable revised determination.)

27520.005 DDS Action Upon Receipt of Informal Remand Cases

A. Operating Policy

The case will be reviewed by an adjudicator who **did not** participate in either the initial or reconsideration determination.

B. Operating Procedures

1. CASE SCREENING OF FO REFERRALS

The following guides apply to cases received from the FO per DI 27520.001 C.

- a. Review the case immediately and prepare a revised allowance (or continuance) on the basis of the evidence in the folder, where warranted. (See DI 27520.005B.3)
- b. If a fully or partially favorable revised determination cannot be made on the basis of the evidence of record, forward the folder and the request for hearing to the OHA office specified on the HA-501-U5 within **7 calendar days from the receipt of the folder in the DDS.**
- c. Indicate on the route slip (SSA-408) to OHA that favorable DDS action could not be taken on prehearing review. (Do not send a letter to the claimant in this situation.)

2. INFORMAL REMANDS FROM OTHER SOURCES

The DDS will retain and complete action per DI 27520.005 B.3. on the following:

B. Operating**Procedures (Cont.)****2. INFORMAL REMANDS
FROM OTHER
SOURCES (Cont.)**

- a. Hearing requests received while the DDS is reopening its adverse reconsidered determination in order to make a favorable decision.

NOTE: If a hearing request is filed while a case is in the DDS because of an SSA-1774-U5 return, and the determination cannot be reopened and favorably revised, send an annotated copy of the SSA-1774-U5 to the disability quality branch (DQB) or DDQO in accordance with DI 27010.015.

- b. Hearing cases received from OHA for additional development which can be reopened and revised to a fully favorable determination as a result of the additional evidence. (If only a partially favorable determination can be prepared, return the case to OHA without any determination being prepared.)

When a hearing has already been held, the OHA office will not send the folder with the development request. In these instances, the development should be returned with no determination prepared.

NOTE: If a fully favorable revised determination cannot be made on the basis of new medical evidence, forward the folder with additional evidence to OHA within 7 calendar days from receipt of the signed medical evidence.

NOTE: Hearing cases received from OHA where the reconsidered determination was rendered by a DHO or by OD should be forwarded to the DHU or OD for consideration of reopening when it appears that a fully favorable determination can be made.

3. REOPENING PROCESS

- a. When a title II reversal is warranted:

- Follow the usual process for a revised determination per DI 27530.010 B. In addition, show "Informal Remand Case" in the remarks section of the determination form (SSA-831-U5).

NOTE: The DDS does not need to notify the claimant in title II reversal cases.

- Annotate the route slip (SSA-408) "Informal Remand Case" and route the folder in accordance with the reconsideration reversal instructions in DI 32005.000 ff.
- Strip and route the determination form in accordance with DI 32015.000 ff.
- Send a photocopy of the determination form to OHA.

- b. When a title XVI reversal is warranted:

- Follow the usual process for a revised determination per DI 27530.010 B. In addition, show "Informal Remand Case" in the remarks section of the determination form (SSA-831-U5).
- **Prepare and release a notice** of the revised determination on an SSA-L8165-U2 (Supplemental Security Income Notice of Decision). Add paragraph 1414, 1415, 1424 or 1425 if a medical reexamination applies. (See model language in exhibits at DI 27520.035.)

NOTE: In partially favorable decisions, include a personalized attachment per DI 27025.015 B.

- Release one copy of the notice to the claimant (and representative), retain one copy in the folder, and provide two copies to OHA.
- Annotate the route slip (SSA-408) 'Informal Remand Case' and forward case to FO.

- c. When a concurrent title II-title XVI reversal is warranted:

- Process the title XVI action, prepare notice, and notify OHA in accordance with instructions above.
- **Forward folders** to the FO for action on the title II claim under the District Office Final Authorization process.

27520.010 Death After Medical Denial or Cessation

- A. Introduction** Notice of a claimant's death after denial or cessation of disability benefits may raise a question as to whether the prior determination should be changed.
- B. Operating Policy** The DDS that made the original determination will review the file for possible reopening when:
- The claimant's death raises a question as to whether the prior determination should be changed, and
 - The claimant died less than 1 year after a denial or termination of disability, and
 - The survivor's benefits would be increased by an allowance (or continuance), or there is a potential DIB underpayment and an individual is eligible to receive the under payment. (The FO will identify these circumstances for the DDS.)
- C. Related Policy** See DI 23510.000 for further instructions on processing cases where the claimant dies after filing for disability benefits.

27520.015 Previous Denial, Closed Period or Termination Based on Failure to Follow Prescribed Treatment

- A. Introduction** Once an adverse action is taken on the basis of failure to follow prescribed treatment, the fact that the individual may later agree to follow such treatment cannot be the sole basis for revising the previous determination.
- B. Operating Policy** A revision is warranted only when it can be determined that the determination based on "failure" was incorrect. For example:
- the treating source did not actually prescribe the treatment; or
 - the treatment could not have been expected to restore the claimant's capacity for SGA (or gainful activity, as appropriate); or
 - a good cause for failure to follow prescribed treatment did exist.
- C. Policy Principle** Where revision is not warranted, and if entitlement is established, the onset date could be that date when the claimant first arranged to follow prescribed treatment. For entitlement to benefits, the impairment must then not only meet the severity requirement but also be expected to last 12 continuous months from the onset date thus established. Also, the insured status and other nondisability requirements must be met.
- D. Related Policy** See DI 23010.000 ff. for a detailed discussion of failure issues.

27520.020 Prior Favorable or Unfavorable Title II Determination or Decision—Felony Related Impairment**A. Policy Principles****1. DENIED DETERMINATION OR DECISION**

Reopen at any time to consider any excluded impairment because the claimant's felony conviction has been overturned.

2. ALLOWED DETERMINATION OR DECISION

- a. Reopen at any time to exclude a felony-related impairment from consideration because the claimant has been convicted of a felony.
- b. If the determination or decision must be revised to a denial or other unfavorable decision, assure that appropriate due process predetermination notification is given.
- c. Reopen at any time to consider an earlier onset if exclusion of a felony-related impairment resulted in a later onset and the claimant's felony conviction has been overturned.

B. Operating Procedure

Follow the instructions in DI 23501.000 ff. when a prior determination must be reopened and revised.

27520.025 Erroneous Notice/ Payment Cases**A. Introduction**

DDSs may encounter cases with a DDS denial or determination or closed period determination, but because of a clerical decisional error the claimant received an allowance or continuance notice and payments.

B. Operating Procedures**1. APPLY RULES FOR REOPENING**

Apply the rules for reopening in DI 27505.001 B. and determine if reopening is possible. Reopening is possible within 2 (title XVI) or 4 (title II) years of date of notice of the initial determination due to **error on the face**.

2. REOPENING PERMITTED

Handle an erroneous notice and payment reopening just as any other reopening. However:

- If the claim is a title II only claim, explain that due to clerical error the claimant received incorrect payments and notice even though the DDS had determined that the claim should be denied. Apply due process as indicated in DI 27525.015.
- For title XVI cases, prepare a copy of the reverse side of as SSA-L8156-U2 and forward it along with the revised notice to the DQB.

3. REOPENING IS NOT PERMITTED

If the situation cannot be corrected under the rules for reopening because the time period has expired, process the case as a CDR.

27520.030 Conflicting Determinations or Decisions in Disability/ Blindness Common Issue Claims**A. Introduction**

The DDS has primary responsibility for conforming conflicting determinations/ decisions in common issue claims in accordance with the policy on adoption of prior claims and refilings for the same period (DI 27515.000 ff. and DI 27516.000 ff.).

B. Operating Policy**1. DETERMINATIONS ON BOTH CLAIMS WERE MADE BY THE DDS AT INITIAL OR RECONSIDERATION LEVEL**

- a. The DDS must conform the determinations. (See "b" below for exception.) The rules for reopening (DI 27505.000 ff.) and due process (DI 27525.000 ff.) must be applied in reopening and reversal situations.
- b. **DDS ISSUED FAVORABLE RECONSIDERED DETERMINATION ON ONE TITLE AND AN UNFAVORABLE INITIAL OR REVISED INITIAL DETERMINATION ON THE OTHER TITLE:** If the favorable determination is found to be erroneous, the DHO will be responsible for resolving the conflict.
- c. Where two DDS's are involved, the one that made the latest determination will usually have jurisdiction in resolving the conflict.

2. DETERMINATION OR DECISION ON ONE CLAIM MADE AT THE DHO, ALJ, OR AC LEVEL

- a. If there is no new and material evidence, the DDS should give priority to the determination or decision made at the higher level and prepare a revised determination except where:
 - **DDS ISSUED FAVORABLE RECONSIDERED DETERMINATION ON ONE TITLE AND DHO ISSUED UNFAVORABLE DETERMINATION ON THE OTHER TITLE:** The DHO will be responsible for resolving the conflict.
 - **DDS ISSUED FAVORABLE RECONSIDERED DETERMINATION ON ONE TITLE AND ALJ OR AC ISSUED UNFAVORABLE DECISION ON THE OTHER TITLE:** The ALJ or AC will be responsible for resolving the conflict. If this situation arises, forward the claims to OHA's central office.
 - **DDS ISSUED FAVORABLE INITIAL OR REVISED INITIAL DETERMINATION ON ONE TITLE AND ALJ OR AC ISSUED UNFAVORABLE DETERMINATION:** The ALJ or AC will be responsible for resolving the conflict. If this situation arises, forward the claims to OHA's central office.
- b. If there is material evidence which was not available to the DHO, ALJ or AC, process as follows:

DI 27520.030B.3.

B. Operating Policy

(Cont.)

2. DETERMINATION OR DECISION ON ONE CLAIM MADE AT THE DHO, ALJ, OR AC LEVEL (Cont.)

- Route conflicting DDS-DHO determinations to the DHU.
- Route conflicting DDS-ALJ (or AC) decisions to the Associate Regional Commissioner (ARC) Programs if the ALJ (AC) decision was favorable. The ARC will coordinate with the OHA Regional Office, or as necessary through the Office of Disability (OD) with the OHA Central Office, as to which component (DDS or OHA) should conform the decisions.
- Route conflicting DDS - ALJ (or AC), decisions to OHA's central office if the ALJ (AC) decision was unfavorable.
- Identify the conflict and show the reasons for referral on the route slip.
- If the DDS must conform the decisions, the cases will be returned. Follow the applicable rules for reopening and due process when reversing a favorable determination.

3. DECISION ON EITHER CLAIM IS PENDING AT THE DHO, ALJ, OR AC

When the DDS has made a favorable initial or reconsideration determination on one claim and DHO or ALJ hearing has been requested on a less favorable determination on another claim:

- Phone the DHU or OHA office and request that the hearing case be returned for reopening and reversal of the prior determination or that the claim be escalated.
- If DHO or ALJ chooses not to return the folder or escalate the claim, wait for the decision and adopt if necessary.

4. ALJ HEARING DECISION

If the DDS discovers a conflict in decisions by ALJ's, forward both cases to the ARC, Programs for coordination with the OHA Regional Office.

5. RELATED POLICY

See DI 33020.025 C. for the DHU responsibility.

27520.035 Exhibits: Model Language For Title XVI Applicants Informal Remands

Exhibit 1 Letter to Title XVI Appellant Advising that We Have Revised Our Denial Determination to be Wholly Favorable and that a Hearing May Not be Necessary

"As a result of our additional review, your supplemental security income claim has been allowed because it has now been determined that your disability prevents you from engaging in substantial gainful work. Therefore, it is not necessary to have your case decided at the hearing level. You will soon get a notice about the amount of your payments.

If you agree with our revised determination, you need take no further action and your hearing request will be dismissed. If you disagree with our revised determination, you may request that the Office of Hearings and Appeals proceed with your pending request for hearing. Your request should be made in writing and filed within 30 days from the mailing date of this notice. Your request may be filed with any social security office.

If you do not request that the Office of Hearings and Appeals proceed with your hearing within 30 days, but you change your mind at a later date, you may still request a new hearing. This request should be in writing and filed with any social security office within 60 days of the date you received this notice."

Exhibit 2 Letter to Title XVI Appellant Advising that We Have Revised Our Denial Determination to be Partially Favorable and that He/She May Request Dismissal of the Hearing Request

"As a result of our additional review, your supplemental security income claim has been allowed with payments beginning at a later date than you expected. This is because we have found that your disability began _____, not at an earlier date. This is the first date the facts about your claim, including the medical evidence, show your condition first prevented you from doing substantial gainful work. We have explained our decision on the attached page. You will soon receive a notice about the amount of your payments." (In closed period case, change the wording in the first paragraph to reflect that the disability has ended. Give the beginning and ending dates of the disability.)

"If you agree with this decision, please advise your social security office within 30 days and your hearing request will be dismissed. If you do agree to the dismissal of your current request for hearing, but you later change your mind, you may still request a new hearing. This request should be in writing and filed with any social security office within 60 days of the date you receive this notice.

If you do not agree, you need take no further action and the Office of Hearings and Appeals will proceed with your pending request for hearing."

BASIC
SSA Pub. No. 68-0427500
January 1986

Audience: DO/BO/TSC: OS, RR;
PSC: CA, CRTA, DE, DEC, DTE, IES,
RECONR; ODO: BATA, CATA, DE, DEC, DS,
ER, IS, ISTA, PLS, RCOVTA, RECONC;
INTPSC: CIES, ERE, FCR, FDE, RECONC;
DDS: ADJ, DHU

Originating Office: SJH-92

PROGRAM OPERATIONS MANUAL SYSTEM
Part 04 - Disability Insurance
Chapter 275 - Reopenings and Administrative Finality
Subchapter 25 - Reopenings - Due Process

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Background

Part 04 (Disability Insurance) of the Program Operations Manual System (POMS) has been reorganized into three user-component segments following a work or case flow sequence. These segments are: district office (DO) procedures; disability determination services (DDS) procedures; and processing center (PC) procedures.

This transmittal contains material for the DDS procedures segment. The material does not change existing policy and procedures (unless specifically noted in the "Explanation of Manual Changes.") However, it may clarify or simplify certain existing instructions. In addition, references to the Social Security Act and the Code of Federal Regulations have been added where appropriate.

Explanation of Manual Changes

This subchapter explains the due process procedures in adverse reopening cases. There is clarification of due process pre-determination notice as compared to due process decision notice and Goldberg/Kelly provisions as compared to P.L. 98-460 benefit continuation provisions.

CONVERSION CHART

BASIC 1-86

Chapter 275 - Reopenings and Administrative Finality Subchapter 25 - Reopenings - Due Process

<i>Old POMS Disability Insurance (DI) Reference</i>	<i>New POMS Reference</i>
00501.520 C.	DI 27525.005
00501.520 D.	DI 27525.010
00501.520 E.	DI 27525.015
00501.540	DI 27525.010
00505.001	DI 27525.001
00505.100 C.	DI 27525.001
00505.105	DI 27525.001
00505.105 C.	DI 27525.020
00505.200 A.	DI 27525.001

<i>Old POMS Disability Insurance (DI) Reference</i>	<i>New POMS Reference</i>
00505.200 E.	DI 27525.020
00505.200 F.	DI 27525.020

New Material

DI 27525.001 B.
DI 27525.010

27525.000 Reopenings - Due Process

	Section
General.....	27525.001
Title II - Due Process in Adverse Reopenings.....	27525.005
Title XVI and Concurrent Title II/Title XVI - Due Process in Adverse Reopenings.....	27525.010
Due Process in Erroneous Payment Cases.....	27525.015
Allegations of Improper or No Due Process.....	27525.020

Reopenings - Due Process

27525.001 General

A. Background

Recent years have seen a continuing increase in the number of disability claims appealed through the court level. This trend is expected to continue in the future. In addition to the increased appellate activity, protection of the claimant's rights with regard to premature cessation or termination of disability benefits continues to receive particular emphasis at all levels of appeals.

B. Definition

Due process includes providing that information which must be conveyed to the beneficiary before taking any action which will adversely affect his/her previously established right to receive title II disability and title XVI disability/blindness benefits. Certain legally established prerequisites must be included in every instance.

Due process in the disability program is achieved by two methods:

1. a due process *pre-determination* notice or
2. a due process *decision* notice.

The due process *pre-determination* notice is prepared and released by the DDS prior to processing of the SSA-831/SSA-832/SSA-833. The case is held in the DDS for a specified time frame in which the claimant has the right to submit additional evidence and/or provide additional input into the decision. A due process *pre-determination* notice is only applicable in those reopening cases that do not require benefit continuation language (i.e., the determination is not considered to be a medical cessation). A due process *decision* notice is provided when benefit continuation language is applicable (i.e., a medical cessation). The due process *decision* notice may be prepared and/or released by the DDS, ODO, etc. The due process *decision* notice is released after processing of the SSA-831/SSA-832/SSA-833 and the case is not held in the DDS awaiting claimant response.

The Fifth Amendment to the Constitution provides that no person shall be deprived of property interest without due process of law. The interest of an individual in continued receipt of social security benefits is a statutorily created "property" interest protected by the Fifth Amendment.

The Social Security Administration has long maintained a policy of protecting a disability beneficiary's right to constitutional due process before the taking of any adverse action affecting benefits. The evolution of this policy and the resulting operating procedures have been governed primarily by a series of landmark Supreme Court decisions.

The key issue to be resolved is: At what point has the individual had enough input into the decision in the case to warrant effectuation of the adverse action (decision)? As a general statement, due process requires that the individual be fully informed that his/her benefits may be stopped as a result of his/her not being disabled (cessation); not being entitled to disability benefits/payments on the current application

(adverse reopening); or that erroneous payments have been made after a decision of denial. The beneficiary must be given an opportunity to offer rebuttal evidence and/or respond to the proposed adverse action before the adverse action is taken.

A due process notice must meet specified legal requirements concerning both format and content. Recent litigation requires that certain detailed information be included in all due process notices, since these notices represent the only specific or personalized information the beneficiary will receive before the final decision to cease benefits.

Due process must be extended to the beneficiary in writing. Any doubts regarding the need to provide due process should be resolved in favor of providing it. The requirements of valid due process are not met simply by advising a beneficiary of the possibility that benefits may stop as a result of the disability review. The following sections will discuss in greater detail the due process requirements for specific types of claims.

A due process notice is required in every claim where a less favorable reopening (e.g., revision from an earlier to a later onset date) is being considered. The due process notice must be in writing. A copy of the notice must be kept in the file.

C. Components Responsible for Affording Due Process

NOTE: A due process *pre-determination* notice is not applicable in medical/vocational cessations that require benefit continuation language in the decision notice. In addition, a due process *pre-determination* notice is not applicable in certain medical adverse reopenings (i.e., 1. revision from allowance to denial, 2. revision from allowance to a closed period of disability, 3. revision from continuance to cessation, and 4. revision from cessation to an earlier cessation date) which require benefit continuation language in the decision notice. The due process *decision* notice in adverse determinations with benefit continuation will be prepared in accordance with the instructions in DI 27540.

The DDS's are responsible for preparing a due process *pre-determination* notice in certain adverse reopening cases (including whereabouts unknown, failure to cooperate, change to a later onset, failure to follow prescribed treatment, fraud, etc.).

The District Offices give due process notification in work issue cessations and adverse reopenings involving work issues. The beneficiary and all auxiliary beneficiaries not living in the same household should be notified of any proposed action to stop benefits.

Reviewers in Central Office and the Disability Quality Branch, OA must ensure that the DDS or DO followed appropriate guidelines for affording due process and that the file is properly documented. In those cases which are ceased or reversed to denial in CO or the DQB, the CO/DQB will be responsible for affording appropriate due process before benefits are stopped.

NOTE: The remainder of this subchapter will discuss requirements of the due process *pre-determination* notice. For instructions on due process *decision* notice see DI 27540.

DI 27525.005

27525.005 Title II - Due Process Pre-Determination Notice In Adverse Reopening Cases

A. General

A due process pre-determination notice is required for adverse reopening cases unless the revised determination notice requires benefit continuation language. If an allowance will be revised to a later onset, the beneficiary must be formally notified before the adverse determination is made. The following sections address onset changes. If the DDS is preparing a due process pre-determination notice for whereabouts unknown, see DI 27525.005 C. and modify the language as appropriate.

B. Beneficiary Contact

The beneficiary must be informed in writing (by mail) of the proposed adverse action. The written due process pre-determination notice must meet specified legal requirements in terms of its content to be valid, including a brief and nontechnical description of the evidence on which the proposed adverse action is based. The beneficiary must be given a reasonable opportunity (i.e., 10 days from receipt of notice) to respond in writing. If he/she wishes to obtain and submit additional evidence which may be material in support of his/her claim, he/she may be granted additional time (i.e., 10-20 days) to present the evidence.

1. BENEFICIARY INDICATES NO ADDITIONAL EVIDENCE OR STATEMENT WILL BE SUBMITTED

Under no circumstances will the DDS process the claim before the 15 days expire unless a written statement is received from the beneficiary that no additional evidence will be submitted. If the beneficiary responds in writing stating that no additional statement or evidence will be furnished, place the beneficiary's statement in file and complete processing of the final determination immediately.

2. "DUE PROCESS" BY MAIL

Prepare the due process pre-determination notice on DDS letterhead or the Form SSA-L951-C2 (Social Security Notice). When the SSA-L951-C2 is used, show the DDS address in the body of the notice indicating where to mail rebuttal evidence. The following outline contains those elements which must be addressed in every due process pre-determination notice. These elements have been formulated as a direct result of court decisions. Therefore, the importance of including these cannot be overemphasized. Due process must be furnished in writing. The model letter in 3. below or similar language should be used before a revised determination is made. Because most adverse reopenings occur as a result of sample review returns, the model language pertains to such adverse reopenings. It may be modified for reopenings due to receipt of additional evidence or other causes.

- a. Tell the beneficiary that we are assisting SSA in reviewing his/her case (because new evidence has been received, the case was selected for independent review, we wanted to consider an earlier onset date, etc.)

- b. Notify the beneficiary that based on evidence now in file, it appears that a determination would have to be made that the onset date should be later, etc.).
- c. Include a list and dates of all medical reports evaluated (do not mention unresponsive medical sources). Explain that the determination is being made by an agency of the State and not the individuals or agencies who submit reports.
- d. When the medical sources were unresponsive, include the disclaimer statement that says that additional reports were not obtainable; however, we had enough information to evaluate the claimant's condition.
- e. Provide a brief statement outlining the reasons the beneficiary gave for believing that he/she met the requirements for disability payments.
- f. Provide a brief description of medical severity as of the onset date in unfavorable onset date allowances. However, care must be taken in discussing medical evidence (address unconfirmed allegations by stating that evidence does not reveal any other disabling conditions). A later onset may be established because a prior ALJ or AC decision is binding. In this case explain that the later onset is established because of an administrative law judge or Appeals Council decision which found him/her not disabled through the date of the decision;
- g. When vocational factors were considered in an unfavorable onset date allowance, list the job the claimant was capable of performing up to the date of onset; and
- h. When the claimant's work activity is the reason for an unfavorable onset determination, the information provided in the attachment must cover this issue.
- i. Explain that we are writing to give the beneficiary an opportunity to present any additional evidence for our consideration if the beneficiary believes he/she was unable to work earlier by reason of the impairment.
When the SSA-L951-C2 is used, also explain that the additional evidence must be mailed to the DDS and show the full DDS address.
- j. Indicate that unless we hear from the beneficiary within 10 days from receipt of this notice, a formal determination will be made. Point out that it is important that the beneficiary let us know within 10 days if he/she wants to submit a statement or evidence (even though more time may be needed to submit it).
- k. Explain that when a formal determination is made, the beneficiary and family, if any, will be notified in writing what the determination is and what he/she must do to appeal if he/she disagrees.

3. MODEL LETTER

"Your disability claim has been selected for an independent review by the Social Security Administration. This means your claim is being reviewed for compliance with the disability requirements of the law.

"On behalf of the Social Security Administration (delete this phrase when the SSA-L951-C2 is used), this is to notify you that based on the evidence now in your file a determination will have to be made that you did not become disabled until (*new onset date*). Therefore, the previous determination that your disability began (*old onset date*) will be revised. This proposed determination is being made by an agency of the State and not individuals who furnished the reports."

(Include the information required in items 2.c.-i. above.)

We are giving you the opportunity to present any additional statement or evidence that you want to be considered before a determination is made, if you believe that the previous date your disability began is correct and should not be changed to a later date. If you want to submit a statement or evidence, please send it to us within 10 days from receipt of this notice. (When the SSA-L951-C2 is used, the last sentence must be modified to read "If you want to submit a statement or evidence, please send it to us within 10 days to this address: DDS, Street, City State ZIP Code.")

"If you do not write us within 10 days, a formal determination on the date your disability began will be made. It is important that you let us know within 10 days if you want to submit a statement or evidence even though you may need more time to submit it."

"When a formal determination is made, you (and your family, if applicable) will be notified in writing. If the date your disability began is changed to a later date, your benefit payments may have to be adjusted."

4. FOLDER DOCUMENTATION AND FOLLOWUP

The DDS will set up appropriate diary controls and take action to finalize its determination and send the folder on to ODO, PSC, DQB, or DDQO, as appropriate. The DDS will not follow up with a beneficiary who fails to respond to the letter. If there is no response in 15 days, the DDS will complete its action.

When the beneficiary responds to the letter with a request for more time to get additional evidence, the DDS may allow an additional 10 days after eliciting from the claimant the nature of the evidence, identification of sources, etc., in order to verify that the claimant is actively pursuing the evidence in question.

There may be unusual circumstances which will require the DDS to extend the response time beyond the second 10-day period. These instances should be rare and granted only when, in the judgement of the DDS, reasonable circumstances preclude the beneficiary from obtaining the evidence in question, (e.g., the doctor is out of town for a period of time, etc.). The DDS will not followup with a beneficiary who fails to respond within the second 10-day period. If there is no response within the second 10 days, the DDS will complete its determination no later than the 25th day after the predetermination notice was sent to the beneficiary.

5. ADDITIONAL INFORMATION RECEIVED

When additional information is received, the DDS will prepare (on the DDS letterhead, or the SSA-L951-C2 if this was used for the initial due process

pre-determination letter) a brief acknowledgement including the following language:

"This acknowledges receipt of the additional information you sent to us. It will be considered along with the other evidence in your case in arriving at a determination as to the date your disability began. When the formal decision is made, you will be notified by the Social Security Administration."

NOTE: Do not include any statement as to the significance of the information received.

6. CHANGE IN DATE OF ONSET

If the adverse reopening involves a change in onset date and the beneficiary's response results in a change to a later onset than the date mentioned in the predetermination notice, a second predetermination notice, diary for followup, etc is required.

7. NOTICE TO AUXILIARIES

Prepare the due process notice to the auxiliaries on DDS letterhead or the SSA-L951-C2 (Social Security Notice). When the SSA-L951-C2 is used, show the DDS name and address in the body of the notice.

All beneficiaries whose benefits will be affected must be given advance notice of the proposed adverse action. Contact with the primary beneficiary is considered advance notice for all auxiliaries who are living with him/her. Therefore, a separate notice is not required for auxiliaries who are living with the beneficiary. However, all auxiliaries who are not residing with the beneficiary must be notified of the proposed adverse action at the same time as the primary beneficiary. Due process must be given to the auxiliaries even if they are in suspense; however, the information about "receipt of benefits" and "benefits being paid" must be deleted if beneficiaries are in nonpayment status. Follow the model language in 8. below. Any such notices (including a copy for the file and the auxiliary's representative, if appropriate) must be prepared, dated, and released the same day due process is extended to the primary beneficiary. The address may be obtained from the latest payment form or change of address form in file. If several auxiliaries have the same payee, only one letter is necessary.

8. MODEL DUE PROCESS LANGUAGE FOR AUXILIARIES NOT RESIDING WITH THE BENEFICIARY

"This notice pertains to the benefits you are receiving (or, "your eligibility," if in suspense status) on the claim of (name of primary beneficiary). Based on the evidence now in file it appears that a determination will be made that (name of primary beneficiary) is under a disability as of (new onset date) instead of (old onset date), etc. Accordingly, all benefits being paid (or, "all eligibility," if auxiliaries are in suspense status) on that claim may have to be adjusted. The purpose of this notification is to give you an opportunity to present any additional evidence for consideration.

"Unless we hear from you within 10 days, a formal determination will be made based on the evidence in file. It is important that you submit any statements or evidence you wish to be considered within 10 days or let us know if more time is needed." (When the SSA-L951-C2 is used, add "If you have additional evidence or wish to submit a statement, please mail it to this address: DDS Name, Street, City, State ZIP Code.")

DI 27525.010

"When a formal determination is made, you will be informed in writing what the determination is."

27525.010 Title XVI and Concurrent Title II/Title XVI - Due Process in Adverse Reopenings

Title XVI and concurrent reopenings/revisions which are adverse to the claimant require due process. However, there are no situations in which the DDS will provide a due process *pre-determination* notice.

A. General

Title XVI and concurrent adverse reopenings are covered under statutory benefit continuation or *Goldberg/Kelly*. Benefit continuation as provided under the Act (as amended by P.L. 98-460) requires the claimant to request benefit continuation. *Goldberg/Kelly* provisions automatically continue benefits. The following types of reopenings/revisions are governed by P.L. 98-460 benefit continuation provisions:

1. a revision from an allowance to a denial;
2. a revision from an allowance to a closed period of disability;
3. a revision from a continuance to a cessation; and
4. a revision from a cessation to an earlier cessation date.

Notice instructions for the above case situations are in DI 27540.

The following types of reopenings/revisions are governed by *Goldberg/Kelly* provisions:

- a. whereabouts unknown;
- b. failure to follow prescribed treatment;
- c. fraud;
- d. changing from an earlier onset to a later onset.

Notice instructions for the above case situations are in DI 27540.

B. Title XVI Due Process Applies

Where adverse reopening determinations are being processed on common issues concurrent title II/title XVI claims, the due process requirements applicable to title XVI are also applicable to title II determinations. (NOTE: In common issue claims, it is not necessary for the onset or ending dates in the two determinations to coincide). A statutory hearing is the initial appeal step for both determinations. Payments will continue until a decision is made on the appeal if appeal is made within 10 days of receipt of notice unless the recipient waives payment continuance (see "E" below).

C. Title II Due Process Applies

The title II due process provisions apply in situations where a title XVI determination of continuance is being processed concurrently with a title II adverse reopening determination. A situation where this could occur would be where the title II is reversed to denial because insured status requirements are not met.

D. Individual Receiving Title II Benefits—Ineligible for Title XVI Payments for A Nondisability Reason

Some concurrent title II/title XVI claims involve situations where title XVI payments have been suspended for a nondisability reason and title II payments continue. The provisions contained in section B above will apply to these cases. Should an appeal be requested within 10 days (or if late filing good cause is shown), title II payments may be continued.

If title XVI payments are suspended for 12 consecutive months or more under the codes NR1-N54, SR6, SR7, SR9, T2R and T22, eligibility is terminated under the T31 category. When the title XVI claim is in "T31" status as of the date of DDS action, process the case as a title II-only case and afford due process as in title II. The DDS should make a systems query immediately before the revised determination is prepared to verify whether the T31 action has been processed. If the response shows any status other than a termination (e.g., NR9-N54, SR6-SR9), the case remains a dual entitlement and title XVI procedures apply.

27525.015 Due Process in Erroneous Payment Cases

Occasionally, the DO, PSC or ODO will forward cases to the DDS in which the DDS had prepared a determination of denial, but because of clerical error, the claimant received an allowance notice or payment without any notice. These must be handled just as other reopening cases. Afford due process according to the appropriate instructions above. If the claim is a title II only claim, explain that due to clerical error the claimant received an incorrect notice or payments even though the DDS had determined that the claim should be denied. Modify the model letter in DI 27525.005 B.3. as appropriate. A summary of the evidence and reason for denial must be included. For title XVI cases, prepare a copy of the reverse side of an SSA-L8156-U2 and forward it along with the revised notice to the DQB.

If new evidence is submitted, a reopening and revised determination will be required.

If the claimant received a denial notice, no due process is required before stopping payment. (If multiple notices were sent and one was an allowance notice, due process must be given as above.) Return the file to the DO, PSC or ODO as appropriate.

27525.020 Allegations of Improper or No Due Process

A. General

Situations may be brought to the DDS's attention (by the claimant or by his/her representative), which will require corrective action in terms of due process. If the claimant or his/her representative alleges that due process was not given, or given improperly, and review of the folder confirms this allegation, corrective action must be taken. Where DDS folder review confirms that benefits were suspended or terminated

without giving the beneficiary the procedural due process right due him/her, the deficiency is not cured by providing only a late advance/corrected notice and an opportunity for rebuttal. The only adequate remedy in such cases is to reinstate benefits from the date of the original suspension or termination action. The beneficiary should remain in payment status pending the final determination made on his/her claim, in accordance with the due process procedures.

Also, when there is an allegation of improper/no due process and the folder contains a copy of the due process notice sent, but the file also reflects a bona fide reason for the beneficiary not receiving the notice (e.g., change of address, recent hospitalization, etc.), the DDS should process the case as if no due process was given. Accordingly, provide remedial due process as in B. below. If the due process documentation is not in file, also handle as if no due process was given.

Failure to reinstate benefits could result in a court action to redress a denial of the beneficiary's rights.

The DDS may also receive cases from SSA central office for corrective action under this section.

B. Remedial Due Process - DDS Action

The DDS should begin remedial due process action immediately after discovery or notice of the error. Initially, all incorrectly suspended/terminated benefits must be reinstated from the original date of suspension/termination. The DDS will teletype DO/PSC to request reinstatement of benefits, if the district office has not already done so. (see "NOTE" below regarding SSI reinstatement.) The teletype must contain the following:

1. Title—Title reinstatement
2. Claim Account Number (CAN)
3. BIC that is assigned to the beneficiary (include BIC's for family, if applicable)
4. Surname followed by the first three letters of the individual's given name.
5. Event date—the month of reinstatement—same as month of suspension/termination.

Example:

Title II reinstatement—please reinstate title II payments for: CAN 111-11-1111, BIC-A, Name Jackson, Tho., Event Date 10/78.

In addition to the teletype, the DDS will send a notice to the beneficiary (and family) informing him/her/them of the error and corrective action. This preliminary letter will say that benefits will be resumed to correct a processing error and that the beneficiary will be receiving a check. State in the letter also

that he/she will be contacted later about his/her continuing entitlement to benefits. Prepare this letter on DDS letterhead, or the SSA-L951-C2 (Social Security Notice).

Benefits will be reinstated in the processing center shortly after receipt of the teletype. The DDS will assume that payment has been resumed by the 15th day. On the 15th day after the teletype was sent, the DDS will send the remedial due process letter. The same predetermination notice requirements and procedures outlined in subsection B. will be followed.

NOTE: Request the district office to reinstate SSI payments. Do not send a reinstatement teletype to the processing center in SSI cases.

C. Remedial Due Process - ODO Action

ODO may receive (from the claimant or his/her representative), allegations of improper suspension or termination actions. If review of the folder discloses that benefits were suspended/terminated without proper due process, or where there is some other imperfection relative to the advance notice sent, ODO will reinstate benefits from the date of the suspension/termination action and return the beneficiary/recipient to current payment status pending correction of the due process element in accordance with due process procedures. After reinstating the benefits, ODO will return the case to the DDS/DO for remedial due process action.

D. Allegation of Nonreceipt of Due Process Notice

Where an allegation is made (by the claimant or his/her representative) that no cessation/termination notice was received, proceed as follows.

Review the folder to insure that the advance due process notice complies with existing instructions. If any deficiency exists concerning the due process notice, take corrective action under B. above. If review discloses that a proper due process notice was provided, refer the case to:

Office of Disability
Division of Program Analysis and Technical Policy
Room 3-A-11 Operations
6401 Security Boulevard
Baltimore, Maryland 21235

Include a brief covering note concerning the alleged nonreceipt of the cessation notice.

BASIC
SSA Pub. No. 68-0427500
January 1986

Audience: DO/BO/TSC: OS, RR;
PSC: CA, CRTA, DE, DEC, DTE, IES,
RECONR; ODO: BATA, CATA, DE, DEC, DS,
ER, IS, ISTA, PLS, RCOVTA, RECONC;
INTPSC: CIES, ERE, FCR, FDE, RECONC;
DDS: ADJ, DHU

Originating Office: SJH-92

PROGRAM OPERATIONS MANUAL SYSTEM
Part 04 - Disability Insurance
Chapter 275 - Reopenings and Administrative Finality
Subchapter 30 - Reopenings - Completion of Form SSA-831-U5

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DI 27530.010 A.3.-DI 27530.025(cont.)..	5

Background

Part 04 (Disability Insurance) of the Program Operations Manual System (POMS) has been reorganized into three user-component segments following a work or case flow sequence. These segments are: district office (DO) procedures; disability determination services (DDS) procedures; and processing center (PC) procedures.

This transmittal contains material for the DDS procedures segment. The material does not change existing policy and procedures (unless specifically noted in the "Explanation of Manual Changes.") However, it may clarify or simplify certain existing instructions. In addition, references to the Social Security Act and the Code of Federal Regulations have been added where appropriate.

Explanation of Manual Changes

This subchapter gives instructions for completion of the SSA-831-U5 for title II and title XVI reopening cases. Instructions are also included for processing adverse reopening cases.

Chapter 275 - Reopenings and Administrative Finality**Subchapter 30 - Reopenings Completion of Form SSA-831-U3****OLD POMS Disability
(DI) Insurance Refer-
ence****New POMS
Reference**

00501.510 E	DI 27530.020
00501.518 B	DI 27530.005
00501.518 C	DI 27530.005 B
00501.530	DI 27530.001
00501.535	DI 27530.015

**OLD POMS Disability
(DI) Insurance Refer-
ence****New POMS
Reference**

00501.545	DI 27530.025
00501.740 E	DI 27530.025
01003.210	DI 27530.010

27530.000 Reopenings - Completion of Form SSA-831-U5

	<i>Section</i>
General.....	27530.001
Processing Adverse Reopening Cases.....	27530.005
Notices and Other Actions In Common Reopening and Related Situations.....	27530.010
Completion of Form SSA-831-U5 in Title II Reopening Cases.....	27530.015
DDS Responsibilities for Indicating Period of Retroactivity in Title II DIB Claims.....	27530.020
Completion of Form SSA-831-U5 in Title XVI Reopening Cases.....	27530.025

Reopenings - Completion of Form SSA-831-U5

27530.001 General

If after applying the conditions for reopening and revision the DDS concludes that the prior initial, reconsidered or revised determination should be changed, (or new and material evidence is received that relates to the period adjudicated) a new Form SSA-831-U5 will be prepared.

The process for handling reopened determinations generally parallels that for reconsideration cases. The revised determination should be set out in the same type of form, i.e., SSA-831-U5 that was used in preparing the original determination in question.

27530.005 Processing Adverse Reopening Cases

A. DDS Reopening of a Disability/Blindness Determination

Because of new and material evidence (see B. below, for guides on handling the receipt of additional medical evidence), postadjudicative reviews, etc., DDS's will at times be required to initiate adverse reopening procedures to correct a previous determination. (See DI 32005.095 for routing revised determinations based on returns from ODO or OA.)

1. TITLE II-ONLY

When a previous determination must be revised and corrected, prepare a revised SSA-831-U5 entering the remark in item 34: "This revises previous determination of (date)." Do not strip the SSA-831-U5, but prong file on the right side of the folder. Do not input the decision. Also prepare and release a notice of a revised determination in accordance with DI 27540.000. Route the folder to the DO via an SSA-408, annotating in remarks: "Title II Adverse Revision - Benefits Continuing."

2. TITLE XVI OR CONCURRENT TITLE II-TITLE XVI

In a title XVI or title II-title XVI case the DDS will prepare a revised SSA-831-U5, in accordance with DI 27530.025 (title XVI) and DI 27530.015 (title II), entering the following remark in item 34 (SSA-831-U5) "This revises previous determination(s) of (date)."

a. Title XVI Only

The DDS will manually prepare and release a notice of the revised title XVI determination in accordance with the guides in DI 27540.000. Route the folder to the DO via an SSA-408, annotating in remarks "Title XVI Adverse Revision— Benefits Continuing."

b. Concurrent Title II-Title XVI Cases

The DDS will also prepare and release notice of the revised title II determination per DI 27540.000. The title XVI due process requirements will apply to both claims in a concurrent case where the same decision is made on reopening both claims. (The next appellate step is to a hearing.) Route the folder to the DO via an SSA-408, annotating in remarks "Title II-Title XVI Adverse Revision—Benefits Continuing."

3. ONE CLAIM REOPENED

If a decision under only one title is reopened (e.g., if the claimant's Date Last Insured affects the title II claim), the reopening action will be subject to the procedures under that title.

B. Medical Evidence Received Following a Determination

If a DO receives additional medical evidence, they will check to see if it is duplicate evidence. If it is, they will annotate it as "Duplicate Evidence," and place it in the folder. If it is not, or if they do not have the folder, the evidence (and when the folder is in the DO, the folder) will be forwarded to the DDS by route slip with the notation, "Additional evidence received; for your necessary action."

Should a DDS receive additional medical evidence after their release of the folder, the material should be processed in accordance with DI 22520.000.

27530.010 Notices and Other Actions in Common Reopening and Related Situations

A. Revision or Change Is Less Favorable

1. TITLE II ONLY

- a. Notice released on original determination (e.g. Allowance or Continuance)
 - 1) Prepare revised SSA-831-U5.
 - 2) Prepare and release pre-determination notice per DI 27540.000
 - 3) Enter ODO/DL in item 29 of the SSA-831-U5.
- b. Notice not released on original determination (e.g. Allowance Reviewed on a preeffectuation basis)

Correct determination and follow current notification instructions.

2. TITLE XVI ONLY

- a. Notice released on original determination
 - 1) Prepare revised SSA-831-U5.
 - 2) Prepare and release the SSA-L8156-U2 per DI 27540.000 (if necessary modify the suggested format and wording to fit the situation).
 - 3) Prepare revised input form SSA-4648-U3 or instructions to the DO.
- b. Notice not released on original determination
Correct determination and SSA-4648-U3 and follow current notification procedures.

3. CONCURRENT CASES

a. title II

- 1) Notice released on original determination
 - a) Prepare revised SSA-831-U5.
 - b) Prepare and release the SSA-L951 in same manner as indicated for the SSA-L8156-U2 in 2 above. However, modify the language so that it refers to Social Security benefits. DO not indicate the medicaid paragraph, but show disclaimer paragraph 842 and appeals paragraph 305. Include paragraph

DI 27530.010B.

901 if the claimant has been receiving benefits for 24 months.

- 2) Notice not released on original determination
Correct determination and follow current notification procedures.

b. title XVI

Same as title XVI Only instructions in 2. above but add paragraph 841.

B. Revision or Change is More Favorable

1. TITLE II ONLY

- a. Notice released on original determination

- 1) Prepare revised SSA-831-U5.
- 2) If the revision is only partially favorable, follow DI 27540.000.

- b. Notice not released on original determination
Correct determination and follow current Notification procedures.

2. TITLE XVI ONLY

- a. Notice released on original determination

- 1) Prepare revised SSA-831-U5.
- 2) Prepare revised input form SSA-4648-U3 or instructions to the DO.
- 3) Prepare notification instructions in accordance with existing instructions. Enter DO/DL-s in item 29 of the revised SSA-831-U5. If the revision is fully favorable show SSA-L8100-U2 on the SSA-865 followed by:

"This determination is based on another review of your claim dated ____." Include paragraphs appropriate to the determination, e.g., 1029, 1391, 1373. (The appeals paragraph is preprinted on the back of the SSA-L8100-U2).

If a reopening of an initial allowance results in a partially favorable earlier onset date or a denial is reopened to a partially favorable allowance, follow DI 27540.020 B.

- b. Notice not released on original determination
—Correct determination and the SSA-L4648-U3 and follow current notification procedures.

3. CONCURRENT CASES

a. Title II

Same as title II Only instructions (see B.1. above) but add disclaimer paragraph 842.

b. Title XVI

Same as title II Only instructions (see B.2. above) but add paragraph 841.

C. Basis Change Only

1. TITLE II ONLY

- a. Notice released on original determination (e.g., denials)

- 1) Prepare revised SSA-831-U5.
- 2) Prepare and release a notice affirming the original determination (e.g., see DI 27540.025). Attach the personalized rationale.
- 3) Send case to the DO, except if the referring office (e.g., ODO-CO) requests return of the folder.

- b. Notice not released on original determination

Prepare corrected determination and follow current notification procedures.

2. TITLE XVI ONLY

- a. Notice released on original determination (e.g., denials)

- 1) Prepare revised SSA-831-U5.

- 2) Prepare and release a notice on the SSA-L8052-U2/C2. Include the first two guide paragraphs from DI 22520.025. Include Appeals paragraph 878 followed by the third guide paragraph from DI 22520.025. Attach a personalized rationale if the revision is less favorable.

- 3) Return the folder to the DO.

- b. Notice not released on original determination
—Prepare corrected determination and follow current notification procedures.

3. CONCURRENT CASES

a. Title II

Same as title II Only cases, but add disclaimer paragraph "842" to the notice. (See C.1. above.)

b. Title XVI

Same as title XVI Only instructions (see C.2. above), but add disclaimer paragraph "841."

D. No Change in Basis or End Result—Claimant Aware

1. TITLE II ONLY

- a. Notice released on original determination (e.g., allowances or denials)

- 1) Document file regarding any additional evidence. (See DI 27501.035.)
- 2) Prepare and release an SSA-L951 with language from DI 27540.025.
- 3) Return case to referring office (e.g., DO, ODO-CO).

- b. Notice not released on original determination.
Rationalize any additional evidence in the determination and follow current notification procedures.

2. TITLE XVI ONLY

- a. Notice released on original determination (e.g., allowances or denials).

- 1) Document file regarding any additional evidence. (See DI 27501.000.)
- 2) Prepare and release an SSA-L8052-U2/C2 using language from DI 27540.000.
- 3) Return case to referring office (e.g., DO, PSC).

- b. Notice not released on original determination.

Rationalize any additional evidence in the determination and follow current notification procedures.

3. CONCURRENT CASES

a. Title II

Same as title II Only instructions (see D.1. above), but add disclaimer paragraph "842" to the notice.

b. Title XVI

Same as title XVI Only instructions (see D.2. above) add disclaimer paragraph "841" to the notice.

E. No Change in Basis or End Result Claimant Unaware**1. TITLE II ONLY**

- a. Notice released on original determination (e.g., allowances or denials):
 - 1) Document the file regarding any additional evidence per DI 27501.035.
 - 2) No notice is required.
 - 3) Return case to referring office (e.g., DO, ODO-CO.)
- b. Notice not released on original determination
Rationalize any additional evidence in the determination and follow current notification procedures.

2. TITLE XVI ONLY

- a. Notice released on original determination (e.g., allowance or denials):
 - 1) Document the file regarding any additional evidence per DI 27501.000ff.
 - 2) No notice is required.
 - 3) Return the case to the referring office (e.g., DO, PSC).
- b. Notice not released on original determination.
Rationalize any additional evidence in the determination and follow current notification procedures.

3. CONCURRENT CASES**a. Title II**

Same as title II Only instructions (see E.1. above).

b. Title XVI

Same as title XVI Only instructions (see E.2. above).

See DI 27540.000 for a discussion of notices to be sent in the above cases.

27530.015 Completion of Form SSA-831-U5 in Title II Reopening Cases

The following instructions set forth the item by item entries on the SSA-831-U5 that are required in reopening cases. If the item is not listed, leave it blank. Those entries that require completion as in initial cases are listed with a reference to the appropriate POMS section rather than repeating these instructions for reopening cases.

Item	Explanation
2	Enter the three digit DDS code.
3	Enter the date from the SSA-831-U5 on which the original decision was recorded.
4	Enter SSN from folder tab.
5	Claimant's name and address. a. Enter the name and most recent address of claimant, or b. If claimant is now deceased, enter the claimant's name only and "claimant deceased." No address is needed.

Item**Explanation**

- c. If someone applied on behalf of a claimant, the applicant's name should be followed by "for" and the claimant's name. The applicant's address should be used. If the claimant is deceased, the claimant's name should be followed by "deceased". The address of the applicant should also appear in this situation. Enter the name of the SSN holder on whose ER the claim is filed in CDB and DWB claims and for parent determinations.
- 6 Enter the name of the SSN holder on whose ER the claim is filed in CDB and DWB claims and for parent determinations.
- 7 Indicate the type of claim as reflected on original SSA-831-U5.
- 9 Use DOB from the SSA-831-U5 used to record the original decision. Check the "PD" block if decision was a denial.
- 10 When a title XVI reopening is also pending in the DDS, enter "Concurrent title II/title XVI." Also, repeat any remarks appearing on the original SSA-831-U5 which are still pertinent.
- 11 Do not complete since presumptive disability does not apply to reopening cases.
- 11A-11B Complete DO/BO address and code. Change from initial SSA-831-U5 if SSA-1415-U3 or Other form shows a change of DO/BO. See DI 26510.010-DI 26510.040.
- 12 Enter the Regulation—Basis code that is applicable to the reopening determination. See DI 26510.045.
- 15-21 See DI 26510.050.
- 22 Will no longer be completed.
- 23 Check this block except in an escalated claim.
- 24 Indicate the level of claim reflected on the most recent SSA-831-U5.
- 25 See DI 26510.070.
- 25A Check block for SSA-4268-U4/C4 if applicable.
- 26 If an Appendix 2 rule (See DI 25035.001 - DI 25035.010) is met at the time of adjudication in either an allowance, denial, or closed period case, cite the rule after the arrow, e.g., 20201. (The vocational rule block need no longer be checked.)
- 27 For complete instructions on rational preparation, refer to DI 27535.000ff. See DI 26510.080.
- 28 Completion of this block is optional when the DDS prepares and releases a notice. In affirmations of denials complete this item in accordance with DI 27540.000.
- 29 a. In cases where ODO or the DAB prepares and release the denial letter, enter ODO-D/L in this item.

DI 27530.020

Item	Explanation
	b. If ODO or the DQB only reviews and releases the letter, enter whatever notice is prepared by the DDS, e.g., SSA-L8156-U2.
30-33	See DI 26510.090.
34	In addition to the entries outlined in DI 26510.095 the following remarks should be entered, as applicable: "DDS input" (See DI 27530.020 below for an explanation of this remark) "Reopening Reversal (or Affirmation). This Revises Previous Determination dated ____." In informal remand cases, enter "Informal Remand Case."
34A-34B	Complete per DI 26510.100
36	Enter the appropriate code as follows:
Code	Basis of Current Determination
A-6	Reopening and revision of initial allowance
D-6	Reopening and revision of initial denial
A-8	Reopening and revision of reconsideration allowance
D-8	Reopening and revision of reconsideration denial

After preparing the determination, route the case per DI 32005.000.

27530.020 DDS Responsibilities for Indicating Period of Retroactivity in Title II DIB Claims

Claims in which a favorable decision is made on a subsequent title II application that reopens an unfavorable decision of a prior title II application can be processed using the SSA-4648-U3 (DDS Title II/Title XVI Disability Claims control and Determination Input Form). In these reopening situations, the DDS examiner is responsible for annotating item 34 of the SSA-831-U5 "DDS INPUT-LESS THAN 13 MONTHS," which will alert the DDS coder/keyer to code as an initial allowance and transmit both the case control and determination data.

In addition, when a DDS reopens an unfavorable decision and there are 13 or more months of retroactivity to benefits from the current application, (based on the application date, not the adjudication date), the DDS examiner will annotate item 34 of the SSA-831-U5 with the remark, "DDS INPUT-13 MONTH CASE." This remark will alert the coder/keyer to code as an initial allowance and transmit both the case control and determination data, as well as a special "override code." This entry will serve to suppress any final action on the claim, generate an exception code and an alert message to the DO informing them of the reopening. Subsequent actions such as reopenings due to additional medical evidence do not require an entry of DDS INPUT on the SSA-831-U5 as these actions, reported on the SSA-4648, require

case control data only.

NOTE: If the SSA-4648 is used for disability determination data input, place the original copy in the folder on the left prongs. See SM 05905.001 for detailed instructions on disposition of the form.

27530.025 Completion of Form SSA-831-U5 in Title XVI Reopening Cases

Complete the following items:

Item	Explanation
2	Enter the three digit DDS code.
3	Enter the date from the SSA-831-U5 on which the original decision was recorded.
4	Enter SSN from folder tab.
5	Claimant's name and address. a. Enter the name and most recent address of claimant, or b. If claimant is now deceased, enter the claimant's name only and "claimant deceased." No address is needed, or c. If someone applied on behalf of a claimant, the applicant's name should be followed by "for" and the claimant's name. The applicant's address should be used. If the claimant is deceased, the claimant's name should be followed by "deceased". The address of the applicant should also appear in this situation.
8	Indicate the type of claim as reflected on original SSA-831-U5.
9	Use DOB from the SSA-831-U5 used to record the original decision.
10	Check the "PD" block if decision was a denial.
11	When a title II reopening is also pending in the DDS, enter "Concurrent title II/title XVI." Also, repeat any remarks appearing on the initial SSA-831-U5 which are still pertinent.
11A-11B	Do not complete
12	Complete DO/BO address and code. Change from initial SSA-831-U5 if the case was received from a different DO.
15-21	Complete in the same manner as for initial title XVI cases (see DI 26510.000).
22	Enter the Regulation-Basis code that is applicable to the reopening determination. (See DI 26510.000.)
23-24	Complete in the same manner as for initial title XVI cases (see DI 26510.000.)
25	Check this block except on an escalated determination.
25A	Indicate the level of claim reflected on the original SSA-831-U5
26	Complete in the same manner as for initial title XVI cases (see DI 26510.000).
27	Complete in the same manner as for title II reopenings (see DI 27535.000).

<i>Item</i>	<i>Explanation</i>
29	Complete in accordance with DI 27540.000
30-33	Complete in the same manner as for initial title XVI cases (see DI 26510.000).

<i>Item</i>	<i>Explanation</i>	<i>Code</i>	<i>Basis of Current Determination</i>
34	In addition to the entries described in DI 26510.000, the following remarks should be entered, as applicable: "Reopening Reversal (or Affirmation). Revises Previous Determination dated _____"	A-6 D-6 A-8 D-8	Reopening and revision of initial allowance Reopening and revision of initial denial Reopening and revision of reconsideration allowance Reopening and revision of reconsideration denial
34A-34B 36	In informal remand cases, enter "Informal Remand Case." Complete per DI 26510.100 Enter the appropriate code as follows:		

BASIC

SSA Pub. No. 68-0427500
January 1986

Audience: DO/BO/TSC: OS, RR;
PSC: CA, CRTA, DE, DEC, DTE, IES,
RECONR; ODO: BATA, CATA, DE, DEC, DS,
ER, IS, ISTA, PLS, RCOVTA, RECONC;
INTPSC: CIES, ERE, FCR, FDE, RECONC;
DDS: ADJ, DHU

Originating Office: SJH-92

PROGRAM OPERATIONS MANUAL SYSTEM
Part 04 - Disability Insurance
Chapter 275 - Reopenings and Administrative Finality
Subchapter 35 - Reopening Rationale Preparation

New Material	No. of Pages
Conversion Chart.....	1
Table of Contents	
(DI 27535.001-DI 27535.010).....	1
DI 27535.010.....	1

Background

Part 04 (Disability Insurance) of the Program Operations Manual System (POMS) has been reorganized into three user-component segments following a work or case flow sequence. These segments are: district office (DO) procedures; disability determination services (DDS) procedures; and processing center (PC) procedures.

This transmittal contains material for the DDS procedures segment. The material does not change existing policy and procedures (unless specifically noted in the "Explanation of Manual Changes.") However it may clarify or simplify certain existing instructions. In addition, references to the Social Security Act and the Code of Federal Regulations have been added where appropriate.

Explanation of Manual Changes

This subchapter provides instructions for preparing rationales in reopening cases.

Chapter 275 - Reopening and Administrative Finality
Subchapter 35 - Reopening Rationale Preparation

New Material

DI 27535.001

DI 27535.005

DI 27535.010

27535.000 Reopening Rationale Preparation (X-refer to DI 27536.000ff)

	Section
General.....	27535.001
Incorporation of the Prior Determination.....	27535.005
Reopening Rationale Format	27535.010

Reopening Rationale Preparation

27535.001 General

The disability decision rationale is of critical importance to any determination, but especially so in reopening cases. The criteria applicable to initial claims are also generally applicable to reopened claims. Refer to DI 26515.000ff for a more detailed discussion of the elements of the rationale. The following sections will address elements of the rationale peculiar to reopening cases.

27535.005 Incorporation of the Prior Determination

The sources of evidence used in the prior determination are incorporated using the following introductory paragraph:

The statement of evidence in the prior determination of _____ (date) _____, except as modified herein, is hereby incorporated by reference, but not the inferences, the findings, or the conclusions based thereon.

27535.010 Reopening Rationale Format

Following the incorporation paragraph, the reopening rationale should proceed according to the format below.

- A. A citation of any new or additional medical evidence;
- B. A review of the claimant's allegations, including impairments discovered during the development of the claim but not specifically alleged by the claimant.
- C. A discussion of the technical issues involved in the case. This will include the statement: "This

determination reopens and revises the previous determination(s) dated _____." (All determinations being reopened must be specified, if applicable.)

- D. A statement of the conditions under which the prior determination is being reopened (e.g., new and material evidence; error on the face of the evidence, etc.).
- E. A statement as to why the prior determination is incorrect.
- F. A discussion of the findings (medical, vocational, etc.) produced by the sequential evaluation process. This must be a thorough explication of each finding pertinent to the case. If the determination is being reopened because of new and material evidence, a discussion of the materiality of new evidence to the period covered by the proper determination, and how this evidence revises the findings covered by the prior determination.

NOTE: A favorable finding on a subsequent application, with an onset date within a previously adjudicated period must always contain a detailed rationale as outlined above, in order to trigger payment on the prior application.

A delineation of the basis for the revised disability determination. In the case of a fully favorable determination, the following statement should be included:

"Disability is therefore established _____ (date) _____ and continues to date." In partially favorable (i.e., closed period) cases, the statement should read: "Disability is therefore established _____ (date) _____ and continued through _____ (date of cessation) _____."

NOTE: The 1984 Amendments have established the applicability of the Medical Improvement Review standard to closed period cases. Refer to the CDR chapter for a more detailed discussion of this standard.

**27536.000 Simplified Reopening Rationale Procedures for Fiscal Year
(FY) 1987**

	<i>Section</i>
Background.....	27536.001
Issues Requiring Rationalization/Documentation in the Disability Decisionmaking Process in Reopening Initial Decisions.....	27536.005
Issues Requiring Rationalization/Documentation in the Disability Decisionmaking Process in Reopening CDR Decisions	27536.010
Reopening of Prior Determination	27536.015
Optional Use of a Decision Rationale.....	27536.020

27536.001 Background

A series of disability work simplification initiatives which can improve productivity in the disability program while maintaining a high quality work product have been developed. One initiative is to suspend, during FY 87, the preparation of summary decision rationales as previously required by DI 27535.000ff. Because these summary decision rationales largely contained information documented elsewhere in the file, it is felt that they were duplicative and therefore do not need to be repeated separately. The charts in DI 27536.005 and DI 27536.010 show the issues that are currently required to be rationalized/documentated in the disability decisionmaking process and where they will usually be documented in the file so that they

do not have to be repeated in a separate summary decision rationale. If these issues are not documented elsewhere in the file, the simplified procedures provide that a brief supplemental rationale be prepared (see DI 27536.005 and DI 27536.010). Specific instructions, outlining these situations, are provided in DI 27536.015.

During the one-year simplification period, a study will be conducted to determine the effect of the new procedures on the accuracy and consistency of decisionmaking. After the study, a decision will be made regarding the ongoing preparation of decision rationales needed to document our disability determinations.

27536.005 Issues Requiring Rationalization/Documentation in the Disability Decisionmaking Process In Reopening Initial Decisions

Where Usually Documented In File Action Required If Not Already In File

1. Evidence Sources

- a. Allowances
 - o Medical evidence
 - o Personalized notice (partially unfavorable decisions)
- b. Denials
 - o Medical evidence
 - o Personalized notice

2. Allegations

- a. Allowances
 - o SSA-3368-F8 (Disability Report of Medical Evidence)
 - o Report of Contact (SSA-5002)
 - o SSA-795 (Statement of Claimant or Other Person)
 - o Personalized notice (partially unfavorable decisions)
- b. Denials
 - o SSA-3368-F8 (Disability Report of Medical Evidence)
 - o Report of Contact (SSA-5002)
 - o SSA-795 (Statement of Claimant or Other Person)
 - o Personalized notice

3. Evidence of SGA/SGA Findings

- a. Allowances
 - o SSA-820-F4 (Work Activity Report - SE)
 - o SSA-821-F4 (Work Activity Report - EE)
 - o Report of contact or SSA-553 (Special Determination)
- b. Denials
 - o SSA-820-F4 (Work Activity Report-SE)
 - o SSA-821-F4 (Work Activity Report - EE)
 - o Report of contact or SSA-553 (Special Determination)

4. Medical Facts

DI 27536.005 (Cont.)

	<i>Where Usually Documented in File</i>	<i>Action Required if Not Already in File</i>
a. Allowances	- o Medical evidence - o Reports of contact	
b. Denials	- o Medical evidence - o Reports of contact	
5. Interpretation of Medical Findings		
a. Allowances	- o Regulation basis code (SSA-831-U5) - o In some cases, the Psychiatric Review Technique Form (PRTF - SSA-2506-BK) and Residual Functional Capacity (RFC - SSA-4734-F4 and Supplement) - o Personalized notice (partially unfavorable decisions - later onset date and closed period cases)	o Supplemental rationale - see DI 27536.015 D.8. (closed period cases only)
b. Denials	- o Regulation basis code (SSA-831-U5) - o Personalized notice - o In some cases, the PRTF and RFC forms	o See items 6, 7 and 8
6. Pain-Related Issues		
a. Allowances	- o Any medical listing which specifically mentions pain - o RFC form - o PRTF form	
b. Denials	- o RFC form - o PRTF form	o Supplemental rationale - see DI 27536.015 D.5.
7. Resolution of Conflicting Treating Source Opinion		
a. Allowances	o Resolved by the determination of an allowance (SSA-831-U5)	
b. Denials	- o RFC form - o PRTF form	o Supplemental rationale - see DI 27536.015 D.4.
8. Resolution of Inconsistencies Material to Decision		
a. Allowances	- o Personalized notice (partially unfavorable decisions - later onset date and closed period cases) - o Resolved by the determination of an allowance (SSA-831-U5)	
b. Denials	- o RFC form - o PRTF form	o Supplemental rationale - see DI 27536.015 D.6.
9. Vocational Rule Used for Medical/Vocational Decisions		
a. Allowances	o Item 27 on the SSA-831-U5	o Supplemental rationale - see DI 27536.015 D.7.

Where Usually Documented In File Action Required If Not Already In File

1. Evidence Sources
 - a. Continuances
 - o Medical evidence
 - b. Cessations
 - o Medical evidence
 - o Personalized cessation notice
2. Basis for the Most Recent Prior Favorable Medical Decision, i.e., Comparison Point Decision (CPD)
 - a. Continuances
 - o Item 22 on the SSA-831-U5
 - o Item 10 on the SSA-832/833-U5(6/85 edition or later)
 - o ALJ, AC, or court decision
 - o Report of contact

DI 27536.010 (Cont.)

- | | Where Usually Documented In File | Action Required If Not Already In File |
|--|---|--|
| b. Cessations | <ul style="list-style-type: none">o Personalized cessation noticeo Item 22 on the SSA-831-U5o Item 10 on the SSA-832/833-U5 (6/85 edition or later)o ALJ, AC or court decisiono Report of contact | <ul style="list-style-type: none">o Supplemental rationale - see DI 27536.015 D.2.1/ |
| 3. Date of CPD | | |
| a. Continuances | <ul style="list-style-type: none">o Prior decisiono DDS developmental worksheet or report of contact | |
| b. Cessations | <ul style="list-style-type: none">o Personalized cessation noticeo Prior decisiono DDS developmental worksheet or report of contact | |
| 4. Reason for Current Review | | |
| a. Continuances | <ul style="list-style-type: none">o Item 20 on the SSA-832/833-U5 (6/85 edition or later)o Diary block on SSA-831-U5 or SSA-832/833-U5o SSA-847-U3 (Request for Case Action)o SSA-5526 (Request for Assistance-Disability)o Diary matured | |
| b. Cessations | <ul style="list-style-type: none">o Personalized cessation noticeo Item 20 on the SSA-832/833-U5 (6/85 edition or later)o Diary block on SSA-831-U5 or SSA-832/833-U5o SSA-847-U3 (Request for Case Action)o SSA-5526 (Request for Assistance-Disability)o Diary matured | |
| 5. Beneficiary's Reason for Continued Entitlement | | |
| a. Continuances | <ul style="list-style-type: none">o Report of work activityo SSA-454-BK (Report of Continuing Entitlement)o Reports of contact | |
| b. Cessations | <ul style="list-style-type: none">o Personalized cessation noticeo Report of work activityo SSA-454-BK (Report of Continuing Entitlement)o Reports of contact | |
| 6. Statement of Nonmedical Issues | | |
| a. Continuances | <ul style="list-style-type: none">o SSA-820-F4 (Work Activity Report-SE)o SSA-821-F4 (Work Activity Report-EE) | |

Where Usually Documented In File Action Required If Not Already In File

- o SSA-454-BK (Report of Continuing Disability)
- o SSA-832/833-U5; SSA-899-U2 (Continuing Disability Review) (Completed by the PSC's)

b. Cessations

- o Personalized cessation notice
- o SSA-820-F4 (Work Activity Report-SE)
- o SSA-821-F4 (Work Activity Report-EE)
- o SSA-454-BK (Report of Continuing Disability)
- o SSA-832/833-U5; SSA-899-U2 (Continuing Disability Review) (Completed by the PSC's)

7. Medical Facts**a. Continuances**

- o Medical evidence
- o Reports of contact

b. Cessations

- o Medical Evidence
- o Reports of contact

8. Discussion of Comparison of Medical Findings Under Medical Improvement Review Standards**a. Continuances**

- o Items 10 and 12 on the SSA-832/833-U5 (6/85 edition)2/
- o In some cases, the Psychiatric Review Technique Form (PRTF- SSA-2506-BK) and Residual Functional Capacity (RFC - SSA-4734-F4 and supplement)

o Supplemental rationale - see DI 27536.015 D.1.

b. Cessations

- o Items 10 and 11 on the SSA-832/833-U5 (6/85 edition)2/
- o Personalized cessation notice
- o In some cases, the PRTF and RFC forms

o Supplemental rationale - see DI 27536.015 D.1.1/
o Supplemental rationale - see DI 27536.015 D.3.1/
o See items 9, 10 and 11

9. Pain-Related Issues**a. Continuances**

- o Any medical listing which specifically mentions pain
- o RFC form
- o PRTF form

b. Cessations

- o RFC form
- o PRTF form

o Supplemental rationale - see DI 27536.015 D.5.

10. Resolution of Conflicting Treating Source Opinion**a. Continuances**

- o Resolved by the determination of a continuance (SSA-832/833-U5)

b. Cessations

- o RFC form
- o PRTF form

o Supplemental rationale - see DI 27536.015 D.4.

DI 27536.015

	<i>Where Usually Documented In File</i>	<i>Action Required If Not Already In File</i>
11. Resolution of Inconsistencies Material to Decision		
a. Continuances	o Resolved by the determination of a continuance (SSA-832/833-U5)	
b. Cessations	o RFC form o PRTF FORM	o Supplemental rationale - see DI 27536.015 D.6.
12. Vocational Rule Used for Medical/Vocational Decisions		
a. Continuances	o Item 14 on the SSA-832/833-U5	o Supplemental rationale - see DI 27536.015 D.7.
b. Cessations	o Item 14 on the SSA-832/833-U5	o Supplemental rationale - see DI 27536.015 D.7.
13. Citation of Jobs and Incidence		
a. Continuances	o Not applicable	
b. Cessations	o Report by a Vocational specialist	o Supplemental rationale - see DI 27536.015 D.9.
14. Assessment of Functional Abilities		
a. Continuances	o RFC form o Medical evidence	
b. Cessations	o RFC form o Medical evidence	
15. Basis for Decision		
a. Continuances	o Items 10 and 12 on the SSA-832/833-U5	
b. Cessations	o Items 10 and 11 on the SSA-832/833-U5 o Personalized cessation notice	

1/ A supplemental rationale is still required even if documented in the personalized cessation notice.

2/ Shows basis code only - supplemental rationale required to explain whether or not MI has occurred.

27536.015 Reopening of Prior Determination

The summary decision rationale, as outlined in DI 27535.000ff., is not required. However, the DDS will handwrite or type the following statements on an SSA-4268-U4/C4:

- A statement of the conditions under which the prior determination is being reopened (e.g., new and material evidence; error on the face of the evidence, etc.);
- A statement why the prior determination is incorrect;
- A discussion of the findings (medical, vocational, etc.) only if pertinent to the reopening decision. If

the determination is being reopened because of new and material evidence, a discussion of the materiality of new evidence to the period covered by the prior determination, and how this evidence revises the findings covered by the prior determination.

- A supplemental rationale is still required to explain the rationalization of the following situations if not documented elsewhere in the file:

NOTE: A supplemental rationale is still required in situations 1-3 even if documented in the personalized cessation notice.

- Discussion of Medical Improvement (MI)—In any decisions in which MI is considered, explain whether or not MI has occurred. The

severity of the impairment(s) considered at the CPD must be compared with the current severity of the same impairment(s) based on comparisons of signs, symptoms and laboratory findings, to determine if there has been any MI. Where the findings demonstrate that there has been MI, explain whether MI is related to ability to work (MI should not be discussed in a title II DIB, CDB, and title XVI adult case if a listing is met or equaled.)

Example:

Current medical evidence reveals that the disabled individual had full weight-bearing status at an examination in February 1986. X-rays interpreted at that time revealed that the fracture was well healed. A consultative orthopedic evaluation was secured since range of motion data were needed. The consulting orthopedic surgeon reported that the individual had good range of motion of both lower extremities. He walked with a normal gait and experienced no difficulty in getting on and off the examining table. His impairment does not meet or equal listing severity.

At the CPD the individual was unable to walk without crutches and x-rays did not show the expected amount of healing. His impairment has decreased in severity since he is fully weight-bearing and an x-ray shows solid union; therefore, medical improvement has occurred. Since the beneficiary met a listing at the CPD but currently no longer meets that listing, the medical improvement is related to the ability to work.

2. **Basis for the Most Recent Prior Favorable Medical Decision i.e., Comparison Point Decision (CPD)**—In cessation decisions, explain the basis for the comparison point decision only if the basis for the prior decision is undocumented.

Example:

The continuance decision of 7/13/81 shows no basis for the decision. A medical/vocational decision was assumed based on vocational rule 201.10 in order to determine if MI is related to the ability to work.

3. **Exceptions to Medical Improvement (MI)**—In cessation decisions, explain the basis for deter-

mining that any exception(s) to MI applies.

4. **Treating Source Opinion**—When the total evidence does not support an opinion furnished by the treating physician that the individual is "disabled," "unable to work," etc., cite the findings or evidence which rebut(s) the treating source opinion.
5. **Pain-Related Issues**—Any allegation(s) or report(s) of pain must be considered in (1) determining whether the claimant has a severe impairment, and (2) at each step in the sequential evaluation process. If there are inconsistencies in the evidence concerning pain, i.e., the claimant alleges limitations or restrictions greater than that reasonably expected based on the objective medical findings, there are conflicts in the evidence, etc., these differences must be reconciled and explained in the file. If these differences have not been dealt with in the RFC or PRTF, then a supplemental rationale stating how the issue of pain was considered in the decision must be prepared.
6. **Inconsistencies Material to the Decision**—Explain any inconsistencies material to the decision, i.e., evidence which might indicate a different decision outcome.
7. **Vocational Rule**—In medical/vocational decisions in initial cases and in assessing ability to engage in SGA in CDR cases, if no vocational rule is met, but the vocational rules are used as a framework for the decision, explain what rules have been considered.
8. **Closed Period Cases**—In closed periods of disability, explain how medical improvement is demonstrated;
9. **Citation of Jobs and Incidence**—In unfavorable decisions, a citation of jobs and incidence, when required.
10. **Court Cases**—Specific issues as required by court case decisions. The DDS should follow the rationale requirements specified in DI 32500.000ff. for the particular court decision.

27536.020 Optional Use of a Decision Rationale

A summary decision rationale as outlined in DI 27535.000ff may still be prepared when required by DDS management, e.g., for training purposes.

BASIC
SSA Pub. No. 68-0427500
January 1986

Audience: DO/BO/TSC: OS, RR;
PSC: CA, CRTA, DE, DEC, DTE, IES,
RECONR; ODO: BATA, CATA, DE, DEC, DS,
ER, IS, ISTA, PLS, RCOVTA, REONE;
INTPSC: CIES, ERE, FCR, FDE, REONE;
DDS: ADJ, DHU

Originating Office: SJH-92

PROGRAM OPERATIONS MANUAL SYSTEM
Part 04 - Disability Insurance
Chapter 275 - Reopenings and Administrative Finality
Subchapter 40 - Reopening Notice Instructions

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New Material	
Conversion Chart.....	1
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(DI 27540.001-DI 27540.045).....	1
DI 27540.010-DI 27540.045.....	5

Background

Part 04 (Disability Insurance) of the Program Operations Manual System (POMS) has been reorganized into three user-component segments following a work or case flow sequence. These segments are: district office (DO) procedures; disability determination services (DDS) procedures; and processing center (PC) procedures.

This transmittal contains material for the DDS procedures segment. The material does not change existing policy and procedures (unless specifically noted in the "Explanation of Manual Changes.") However it may clarify or simplify certain existing instructions. In addition, references to the Social Security Act and the Code of Federal Regulations have been added where appropriate.

Explanation of Manual Changes

This subchapter details the notice preparation instructions for reopenings and revisions of initial cases, initial reconsideration cases and informal remands. This subchapter contains new information and clarification of notice instructions.

Chapter 275—Reopenings and Administrative Finality
Subchapter 40—Reopening Notice Instructions

Old POMS Disability Insurance (DI) Reference New POMS Reference

00501.505	DI 27540.010
00501.520 D.....	DI 27540.010
00501.540	DI 27540.010
00501.785 J.....	DI 27540.030
00505.001	DI 27540.001
00505.100	DI 27540.001
00505.105	DI 27540.001
00505.200	DI 27540.001
01002.010	DI 27540.001
01003.020 C.....	DI 27540.020
01003.020 D.....	DI 27540.010
01003.170	DI 27540.010
01003.180	DI 27540.030
01003.190	DI 27540.030
01003.200	DI 27540.010
	DI 27540.020
01003.210	DI 27540.015

Old POMS Disability Insurance (DI) Reference New POMS Reference

01003.210 A.2.....	DI 27540.030
01003.210 B.2.....	DI 27540.030
01003.210 C.....	DI 27540.010
	DI 27540.030
01003.210 D. and E.....	DI 27540.030
01004.100	DI 27540.040
01006.020 A.1.....	DI 27540.010
01007.450	DI 27540.010

New Material

DI 27540.001
DI 27540.005
DI 27540.025
DI 27540.035
DI 27540.045

27540.000 Reopening Notice Instructions

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Basic Principles - Initial and Reconsideration.....	27540.005
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Title XVI Only - P.L. 98-460 Payment Continuation Applies.....	27540.015
Concurrent Title II-Title XVI Due Process Decision Notice: 98-460.....	27540.020
Title II Only - Pre-determination Notice Previously Mailed - Final Decision Notice Instructions.....	27540.025
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Concurrent Title II/Title XVI - P.L. 98-460 Does Not Apply.....	27540.035
Reopening, Revision and Other Related Situations - Reconsideration Determination Previously Made.....	27540.040
Reopening, Revision and Other Related Situations - Informal Remands.....	27540.045

Reopening Notice Instructions

27540.001 Introduction

A. Due Process Notices

Due process includes providing that information which must be conveyed to the beneficiary before taking any action which will adversely affect his/her previously established right to receive title II disability and title XVI disability/blindness benefits. Certain legally established prerequisites must be included in every instance.

Proper due process in the disability program is achieved by two methods:

1. a due process *pre-determination* notice or
2. a due process *decision* notice.

The due process *pre-determination* notice is prepared and released by the DDS prior to preparation of the SSA-831/SSA-832/SSA-833. The case is held in the DDS for a specified time frame in which the claimant has the right to submit additional evidence and/or provide additional input into the decision. The due process *pre-determination* notice is only provided to those who do not have the benefit of electing payment continuation. (See DI 27525 for *pre-determination* notice instructions.) A due process *decision* notice is provided when payment continuation language is applicable. The due process *decision* notice may be prepared and/or released by the DDS, ODO, etc. The due process *decision* notice is released after preparation of the SSA-831/SSA-832/SSA-833 and the case is not held in the DDS awaiting claimant response.

The Fifth Amendment to the Constitution provides that no person shall be deprived of property interest without due process of law. The interest of an individual in continued receipt of social security benefits is a statutorily created "property" interest protected by the Fifth Amendment.

The Social Security Administration has long maintained a policy of protecting a disability beneficiary's right to constitutional due process before the taking of any adverse action affecting benefits. The evolution of this policy and the resulting operating procedures have been governed primarily by a series of landmark Supreme Court decisions.

The key issue to be resolved is: At what point has the individual had enough input into the decision in the case to warrant effectuation of the adverse action (decision)? As a general statement, due process requires that the individual be fully informed that his/her benefits may be stopped as a result of his/her not being disabled (cessation); not being entitled to disability benefits/payments on the current application (adverse reopening); or that erroneous payments have been made after a decision of denial. The beneficiary must be given an opportunity to offer rebuttal evidence and/or respond to the proposed adverse action before the adverse action is taken.

A due process notice must meet specified legal requirements concerning both format and content. Recent litigation requires that certain detailed information be included in all due process notices, since these

notices represent the only specific or personalized information the beneficiary will receive before the final decision to cease benefits.

Due process must be extended to the beneficiary in writing. Any doubts regarding the need to provide due process should be resolved in favor of providing it. The requirements of valid due process are not met simply by advising a beneficiary of the possibility that benefits may stop as a result of the disability review.

If no benefit continuation provisions are in effect, the beneficiary-recipient must be afforded a due process *pre-determination* notice prior to a final unfavorable or partially favorable determination. This includes adverse reopenings and revisions at both the initial and CDR levels. For further details and model language for *pre-determination* notices see DI 27525.000.

B. Notices

The Social Security Administration is required to provide personalized disability determination notices to primary claimants and beneficiaries/recipients on totally or partially unfavorable disability determinations. The determination notice must contain a statement of the case written in understandable language setting forth a discussion of the evidence and stating the Secretary's determination and the reason or reasons for the determination.

DDS's, PSC's, INTPSC and ODO are urged to use independent judgement in deciding what is to be included in notices not covered by these instructions, provided such decisions are consistent with notice standards outlined in DI 26535.005. The DDS may telephone the ARC-Programs for assistance on any issue. If the issue occurs with some regularity, also submit a written request to the ARC-Programs outlining the issue, the problem it is causing and the solution the DDS believes to be best.

27540.005 Basic Principles - Initial and Reconsideration

These principles apply to final determination notices issued after due process notification *OR* when benefit continuation provisions make due process unnecessary. For information on basic notice styles, Spanish language notices, etc. see DI 26535.000. *If the notice has not been released on the original determination (e.g., a sample review return) correct the original determination and follow current notification instructions.* If the notice has been released, see the following sections.

27540.010 Title II Only - P.L. 98-460 Payment Continuation Election Applies

The following types of reopening/revisions are governed by P.L. 98-460 payment continuation provisions:

- A. a revision from an allowance to a denial;
- B. a revision from an allowance to a closed period of disability;
- C. a revision from a continuance to a cessation;
- D. a revision from a cessation to an earlier cessation date.

1. FULLY FAVORABLE DECISION

- No DDS prepared notice is required.
2. **PARTIALLY FAVORABLE DECISION**
Instructions to be issued in the next transmittal.
 3. **LESS FAVORABLE DECISION**
Instructions to be released under separate cover.
 4. **LESS FAVORABLE - AUXILIARIES (IN SEPARATE HOUSEHOLDS) NOTIFICATION**
Instructions to be issued in next transmittal.
 5. **BASIS CHANGE ONLY**
Instructions to be released in next transmittal.
 6. **NO CHANGE IN BASIS OR END RESULT - CLAIMANT AWARE**

The notice should be prepared on an SSA-L951-U2 and language similar to the following may be used:

"We have received the additional medical evidence concerning your application for Social Security benefits under the provisions of title II of the Social Security Act." (If the additional evidence was submitted by someone other than the claimant, indicate from who, i.e., "submitted by _____.")

"In view of the information received, we have reviewed the evidence in your case and find that the prior determination made on your application is proper and in accordance with the law. Therefore, the decision on your application remains unchanged."

If the period for appealing the decision has not expired, include the following sentence:

"As you were previously advised, if you believe that the determination is not correct you have 60 days from the date you received our previous notice to request a reconsideration/hearing."

"If you have any questions about your claim, you should get in touch with any Social Security office. Most questions can be handled by telephone or mail. If you visit an office, however, please take this letter with you."

7. **NO CHANGE IN BASIS OR END RESULT - CLAIMANT UNAWARE**

No DDS prepared notice required.

27540.015 Title XVI Only - P.L. 98-460

Payment Continuation Applies

The following types of reopenings/revisions are governed by P.L. 98-460 payment continuation provisions:

- A. a revision from an allowance to a denial;
- B. a revision from an allowance to a closed period of disability;
- C. a revision from a continuance to a cessation; and
- D. a revision from a cessation to an earlier cessation date.

Specific instructions are as follows:

1. **Fully Favorable Decision**

No DDS prepared notice is required.

2. **Partially Favorable Decision**
Instructions to be released in next transmittal.
3. **Less Favorable Decision**
Instructions to be released in next transmittal.cover.
4. **Basis Change Only**
Instructions to be released in next transmittal.
5. **No Change in Basis or End Result - Claimant Aware**
Prepare and release an SSA-L8052-UZ/CZ using language from DI 27535.020 ff and DI 27540.030.
6. **No Change in Basis or End Result - Claimant Unaware**
No notice is required.

27540.020 Concurrent Title II-Title XVI Due Process Decision Notice: 98-460

When adverse reopening determinations are being processed on common issues on concurrent title II/title XVI claims, the due process requirements applicable to title XVI are also applicable to title II determinations. Some concurrent title II/title XVI claims involve situations where title XVI payments have been suspended for a nondisability reason and title II payments continue. Title XVI notice provisions will apply in these situations. The title II due process provisions apply in situations where a title XVI determination of continuance/allowance is being processed concurrently with a title II adverse reopening determination. If title XVI payments are suspended for 12 consecutive months or more under the codes N01-N54, S06, S07, S09, T20, and T22, eligibility is terminated under the T31 category. When the title XVI claim is in "T31" status as of the date of DDS action, process the case as a title II only case. The DDS should make a systems query immediately before the revised determination is prepared to verify whether the T31 action has been processed. If the response shows any status other than a termination (e.g., N09-N54, S06-S09), the case remains a dual entitlement and title XVI procedures apply.

A. Fully Favorable

1. **TITLE II**

No DDS notice required.

2. **TITLE XVI**

Same as title XVI only (DI 27540.030 D.1). Add disclaimer paragraph 841.

B. Partially Favorable

Instructions to be issued in next transmittal.

C. Less Favorable

Instructions to be issued in next transmittal.

D. Basis Change Only

Instructions to be issued in next transmittal.

E. No Change In Basis or End Result-Claimant**Aware****1. TITLE II**

Same as title II only (DI 27540.010 D.6.). Add disclaimer paragraph 842.

2. TITLE XVI

Same as title XVI only (DI 27540.030 D.4.).

F. No Change In Basis or End Result-Claimant**Unaware****1. TITLE II**

No DDS prepared notice is required.

2. TITLE XVI

No DDS prepared notice is required.

G. Notice to Auxiliaries In Concurrent Title II-Title XVI Cases

Instructions to be issued in next transmittal.

27540.025 Title II Only -**Pre-determination Notice****Previously Mailed - Final****Decision Notice Instructions**

The following types of reopenings/revisions should have had a due process pre-determination notice (see DI 27525):

- A. whereabouts unknown;
- B. failure to follow prescribed treatment
- C. changing from an earlier onset to a later onset

Specific instructions for the following categories will be issued shortly:

- 1. Fully Favorable Decision
- 2. Partially Favorable Decision
- 3. Less Favorable Decision
- 4. Basis Change Only
- 5. No Change in Basis or End Result - Claimant Aware
- 6. Change in Basis or End Result - Claimant Unaware

27540.030 Title XVI Only - Goldberg/Kelly Applies

The following types of reopenings/revisions are governed by Goldberg/Kelly automatic payment continuation:

- A. whereabouts unknown;
- B. failure to follow prescribed treatment;
- C. changing from an earlier onset to a later onset.

1. FULLY FAVORABLE DECISION

DDS will prepare DO instructions on an SSA-865. On the SSA-865 show the following:

- a. SSA-L8100-U2
- b. "This determination is based on another review of your claim dated _____."
- c. Appropriate paragraphs from the following list:

- 1029 Always appropriate
- 1391 If medical reexam diary established
- 1412 If periodic review scheduled

- 1413 If paragraph 1391 used
- 416 If case has been escalated
- 841 Concurrent Title II-Title XVI
- 1151 or If appropriate for Medicaid
- 1150 If appropriate for Medicaid

2. PARTIALLY FAVORABLE DECISION

The DDS will designate the notice, stock paragraph and provide special language to be sent the claimant. The DO will prepare the notice, include benefit payment information and release it to the claimant. On Form SSA-865 enter SSA-L8100-U2. Include the following:

a. An introductory statement which reads:

"Your claim for Supplementary Security Income benefits was recently reviewed and it has been determined that you meet the disability requirements of the law on (onset date). Attached to this notice is an explanation of the decision we made in your claim and how we arrived at it."

b. If a denial is revised to an allowance indicate the following paragraphs:

- 1) Paragraph 1412 (Periodic Review Scheduled)(or Paragraph 1413 if 1391 is used) unless a closed period is established.
- 2) Paragraph 1396 (Closed Period Blindness) or 1397 (Closed Period Disability) if a closed period is established.
- 3) Paragraph 1382 (Reminder to Report if Condition Worsens) if closed period is established.
- 4) Paragraph 1150 or 1151 (Medicaid Paragraphs) if appropriate.
- 5) Paragraphs 841 (Disclaimer Paragraph) if a concurrent title II/XVI claim is involved. Prepare a personalized rationale addressing the partially favorable determination on Form SSA-4268-U4/C4 following the guidelines in DI 27540.010 B.2.

3. LESS FAVORABLE DECISION**a. Allowance To a Denial**

The reopening and revision of an initial title XVI determination to a denial requires a preparation of a special notice. Obtain a systems query to determine the payments status. If the recipient is in current pay status, the notice must be typed on a Form SSA-L8165-U2 (Notice of Planned Action). (See DI 01007.534) If the title XVI payments are in suspense because of a non-disability related reason, the notice should be typed on Form SSA-8165-U2 (Notice of Decision). (See DI 01007.536) Also, appeals paragraph 878 must be included in the notice.

The following elements must be included in the notice:

- 1) An introductory statement, e.g., "Your claim for Supplemental Security Income payments was recently reviewed and it has been determined that you do not meet the disability

requirements of the law. Therefore, your claim must be denied. This revises the determination recently made that you are entitled to these payments." or, "Your claim for Supplemental Security Income payments has been reexamined because of the receipt of additional evidence. Evaluation of this evidence and the evidence already in your file shows that you do not meet the disability requirements of the law. Therefore, your claim must be denied. This revises the determination recently made that you are entitled to these payments."

- 2) A paragraph from DI 31505.000, which is related to the basis for a denial, e.g., lack of severity;
 - 3) A discussion of the evidence and why it shows that the claimant does not meet the disability requirement in the law paragraph. This discussion must contain the personalized notice elements contained in DI 27540.010 B.2.;
 - 4) If the recipient is in current pay status, include Goldberg/Kelly payment continuation language.
 - 5) If title XVI payments are in suspense because of a nondisability related reason, do not include Goldberg/Kelly payment continuation language.
 - 6) The suggested format and wording may be modified by the DDS examiner to fit the facts in the claim being reopened. However, the elements indicated above must be included in every adverse reopening.
- b. Reopening Allowance Results in Later Onset Date

In those situations in which the DDS prepares a revised determination to reflect a later onset date (a less favorable determination), the guides outlined in 2. above should be followed with the following changes:

- 1) The introductory statement should read, "Your claim for supplemental security income benefits was recently reviewed and it has been determined that you do not meet the disability requirements of the law until (onset date). This revises the determination recently made that you were entitled to these benefits beginning (prior onset date)."
 - 2) A law/decision paragraph is not necessary.
 - 3) A discussion of the evidence and why it shows that a later onset is indicated. This discussion must contain the personalized notice elements in DI 27540.010 B.2.
- c. Basis Change Only

The notice should be prepared on the SSA-L8052-U2-C2 and include:

- 1) "We have received the additional medical evidence concerning your application for Supplemental Security Income payments under the provision of title XVI of the Social Security Act."

"In view of the information received¹ we have reviewed the evidence in your case and find that the prior determination made on your application is proper and in accordance with the law. Therefore, the decision on your application remains unchanged."²

- 2) Appeals Paragraph 878
- 3) "If you have any questions about your claim, you should get in touch with your Social Security office. Most questions can be handled by telephone or mail. If you visit your Social Security office, however, please take this letter with you."
- 4) Attach a personalized rationale, following guidelines in DI 27540.010 B.2., if the revision is less favorable.
5. NO CHANGE IN BASIS OR END RESULT - CLAIMANT AWARE
Prepare and release a notice as shown in DI 27540.015 D.5. above.
6. NO CHANGE IN BASIS OR END RESULT - CLAIMANT UNAWARE
No DDS prepared notice is required.

27540.035 Concurrent Title II/Title XVI - P.L. 98-460 Does Not Apply

The following types of reopenings/revisions are governed by Goldberg/Kelly automatic payment continuation:

- A. whereabouts unknown;
- B. failure to follow prescribed treatment;
- C. changing from an earlier onset to a later onset;
- D. fraud.

Specific instructions for the following categories will be issued shortly:

1. Fully Favorable
 - a. Title II
 - b. Title XVI
2. Partially Favorable
 - a. Title II
 - b. Title XVI
3. Less Favorable
 - a. Title II
 - b. Title XVI
4. Basis Change Only
 - a. Title II
 - b. Title XVI
5. No Change In Basis or End Result - Claimant Aware
 - a. Title II
 - b. Title XVI

¹If the additional evidence was submitted by someone other than the claimant, indicate from whom, i.e., "submitted by _____."

²If the 60 day period for appealing the decision has not expired, include the following sentence: "As you were previously advised, if you believe that the determination is not correct, you have 60 days from the date you received our previous notice to request a reconsideration/hearing." (Show the appropriate appeal right, e.g., show "reconsideration" if acknowledgement pertains to additional evidence received after an initial determination.)

6. No Change In Basis or End Result - Claimant Unaware
 - a. Title II
 - b. Title XVI
7. Notice to Auxiliaries in Concurrent Title II/Title XVI Cases
8. Model Language for Nonresident Auxiliaries

27540.040 Reopening, Revision, and Other Related Situations - Reconsideration Determination Previously Made

Notification instructions for reopening, revision or other related situations after a reconsideration determi-

nation in title II, title XVI and concurrent title II-title XVI claims are the same as for initial claims. Refer to DI 27540.010 through DI 27540.020.

27540.045 Reopening, Revision and Other Related Situations - Informal Remands

The specific requirements for notices in these situations are detailed in DI 27520.020 through DI 27520.045.